# R.N.

*a journal for nurses*

- *Radioactive Isotopes*
- *Authoritarianism in Nursing*
- *Climate: It can kill or cure you!*

COLUMBIA MEMORIAL HOSPITAL SCHOOL OF NURSING

October 1954

# R.N.

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"And I said, 'Anyone who has been around knows KNOX GELATINE as the all-protein-no-sugar-gelatine product.' "

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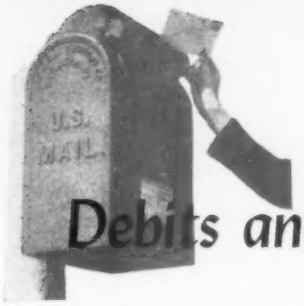


# Debits and Credits

## Nurse Idea Week

Dear Editor:

Why not inaugurate a "National Nurse Idea Week" dedicated to the presentation of ideas from active and inactive nurses? At every hospital throughout the country one nurse could be assigned to collect ideas from the staff, record and submit them to a group of specialists qualified to evaluate them. Then, perhaps, the best of the ideas could be published in the nursing and hospital journals. Readers of such journals could, and doubtless would, lend assistance to the development of any really worthwhile suggestion.

Perhaps such little suggestions would add up through the years—perhaps they would help us to achieve a "hospital utopia."

(Mrs.) M. Hemment, R.N.
HUNTINGTON, N.Y.

## Grateful

Dear Editor:

I would like to thank all the nurses who so generously sent me stamps in answer to the request I made in *D & C* [June, 1954]. So many responded that it surprised me, and the stamps have made quite an addition to my collection. Duplicates were sent to nurses who, along with their contributions, included letters telling me that they, too, were collectors. There was even one nurse who collected postmarks. I enjoyed their letters so much I wish I could answer each one personally. My sincere thanks to all.

(Mrs.) Marguerite Foster, R.N.
HEBRON, ME.

## Shares Suggestion

Dear Editor:

Many treatments necessary for the speedy recovery of a patient are time consuming and entail a great deal of physical discomfort to the patient. Since it is advantageous to doctor, nurse, and patient to reduce both the discomfort and the time element to a minimum, I am reporting on one very minor change that I suggested in the E.N.T. clinic at Walter Reed Army Hospital.

One of the more disagreeable treatments in the E.N.T. field is that of esophageal dilation. We are all familiar with the method used wherein heavy silk braid weighted with a metal bead is swallowed by the patient, providing the doctor with a guide-line from the mouth to gastrostomy opening along which he

can pass the Jackson-Plummer dilators at periodic intervals.

The procedure followed in our clinic was to replace the silk braid prior to each dilation with *one* new strand. During the dilation, on several occasions, apparently the guideline was subjected to too much tension or became frayed by the flexible metal spiral tip of the Jackson-Plummer dilator. The silk braid broke. Consequently, the doctor had to explore the stomach digitally or with an esophagoscope introduced through the gastrostomy in order to locate and retrieve the free end of braid.

To prevent recurrence of these mishaps I suggested: (1) that *two* lengths of braid replace the one just prior to each dilatation, (2) clamp off one strand of braid to one side—this provides a spare if the guideline should break. This minor change was readily adopted by the doctors and proved very successful.

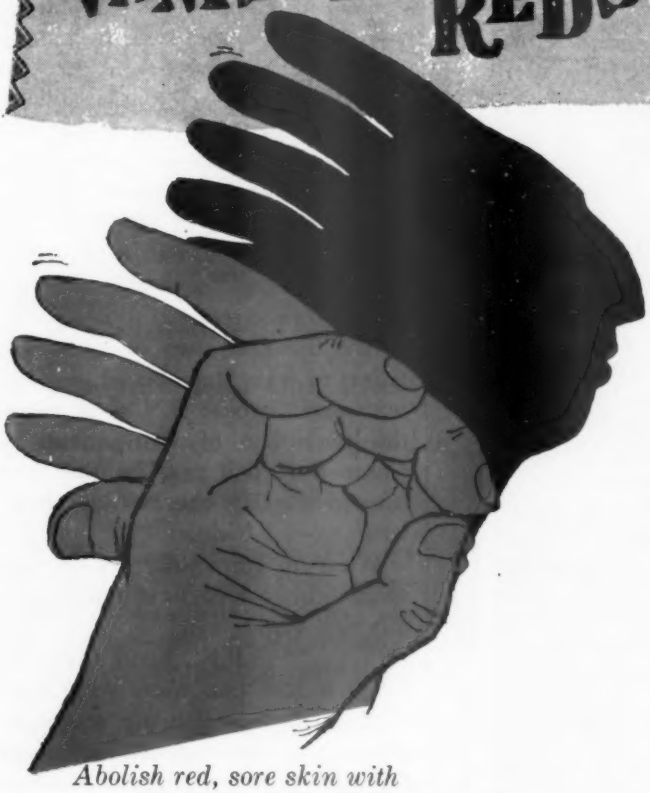
(Mrs.) Elizabeth M. Carl, R.N.
Washington, D.C.

## Two-Year Experiment

Dear Editor:

In *The Newark Evening News* of July 23, 1954, there was an article called "Nurse Degree Speed-Up." It described a two-year plan for nursing certificates, and—to put it mildly—I was very much amazed by it. The paragraph that shocked me was, and I quote: "Probably the biggest time saver is the learn-it-once-right theory which, for instance, keeps student

# VANISHING REDSKIN!



*Abolish red, sore skin with*

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nurses from such tedious and eventually non-instructive hospital chores as bed making. Such tasks, once learned, are not repeated."

How often are nurses grateful that some nursing procedures were so ingrained in them in student days that they can give the patient close attention, knowing that their hands have learned their work so well they are doing the task automatically. Besides, the making of beds has never seemed a chore to me. It is perhaps typical of the "new attitude" that such tasks are referred to as chores.

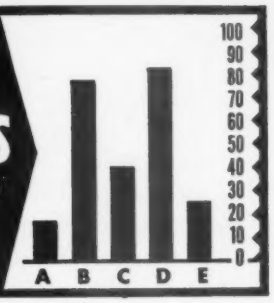
Are the graduates of these programs to take State Board examinations and become R.N.'s? If so, for the protection of the patients on whom they will practice the once-learned nursing chores they should wear special badges.

What do you think? I have seen nothing in your pages in reference to this new experiment.

R.N., BUDD LAKE, N.J.

[*It is a fact that there have been established several two-year nursing schools on an experimental basis.* **R.N.** *first reported on this educational experiment in Canada* [*Oct., 1949*], *has published news items on the two-year schools in the U.S., and intends to feature a full-length article on the subject in the near future. In New Jersey, the first class of two-year students at Rutgers University School of Nursing completed a 24-month course this past summer. New Jersey's Fairleigh Dickinson College also graduated its first class of two-year nursing students this summer. Graduates of these programs must, of*

graphic results in **PSORIASIS** treated with **RIASOL**




**A series of resistant psoriatics who had not responded to other drugs were treated with RIASOL. The graphs show the results in comparison with the general experience of dermatologists.**

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**RIASOL is supplied in 4 and 8 fld. oz. bottles at pharmacies or direct.**

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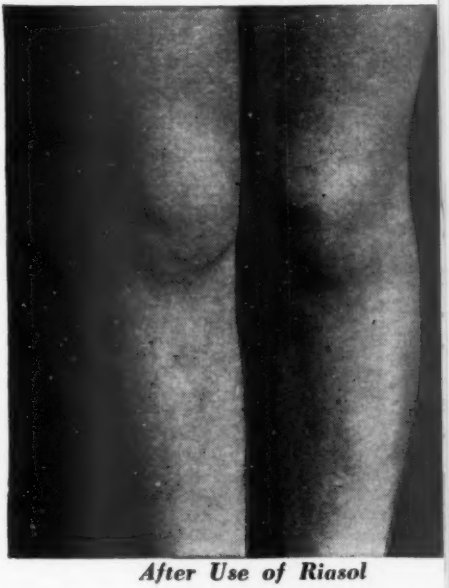

*After Use of Riasol*

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**RIASOL FOR PSORIASIS**

*course, take and pass State Boards before they can call themselves R.N.'s. The nursing profession is assuming a "wait-and-see" attitude toward this experiment in nursing education.*—THE EDITORS]

## Neighborly Advice

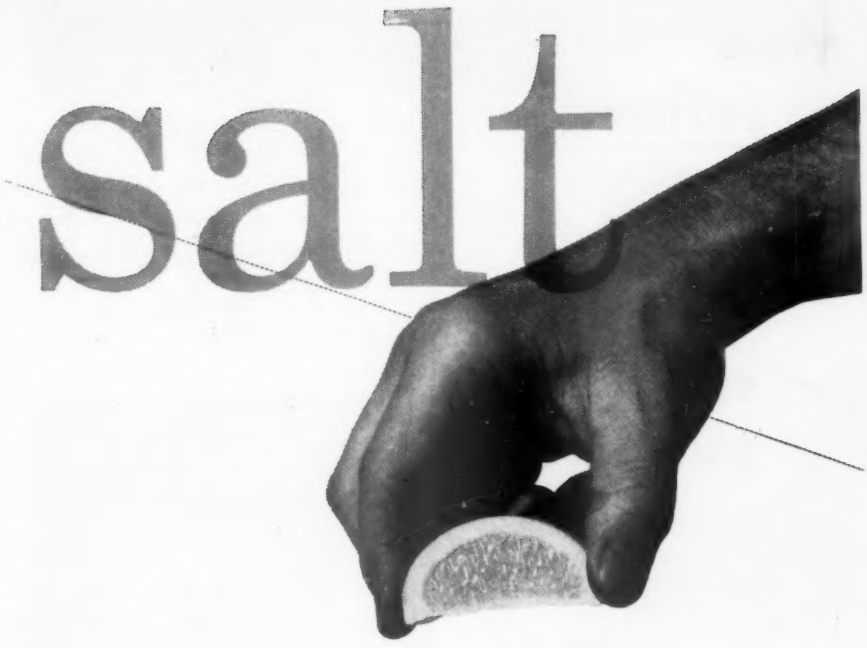
Dear Editor:

When people ask me if I am active in nursing, I always answer "Yes." I have not been on any official payroll for the past two years, but I consider myself active in the education of our young mothers. I, too, am a young mother and I come in contact with many others in my neighborhood. They come to me with their problems and questions during their pregnancy and those hectic, first weeks of motherhood.

I have spent many an hour suggesting that they join the mothers' classes in the nearby Red Cross and Visiting Nurse centers. Some scoff at these suggestions, and inform me that they do not need these lessons since they possess a "strong maternal instinct;" others heed my advice and are happy to attend these informative lectures.

Why don't obstetricians stress these classes to their patients? I know of many women who have asked their physicians about such classes; the doctors just shrugged their shoulders and said, "If you want to go there's no harm in it."

I believe the classes are helpful; they have given confidence to many. Others who do not attend these




## *"But Doctor, how can I eat without salt?"–*

Many doctors and nutritionists report that the *real* problem of the low-sodium diet centers around the unpalatability of the patient's menu. The most frequent complaint is that unsalted foods taste flat, insipid.

The use of fresh lemon juice is proving of genuine benefit to many thousands on low-sodium diets. Patients find that a squeeze of lemon added at the table transforms tasteless, unsalted foods into tempting, appetizing ones. The sharp tang and aromatic flavor of fresh lemon juice compensate for the absence of salt.

Fresh lemon juice has a very favorable ratio of sodium to potassium. It is virtually sodium-free (approx. 1 mg. per 100 cc.) and is relatively high in potassium (130 mg. per 100 cc.).

In weight-reducing diets, when salt restriction is advisable, seasoning with fresh lemon juice adds zest and flavor to low-calorie foods.

Suggest that lemon wedges be placed on the table every meal.

**Sunkist** *fresh lemons*

*"The Low Sodium Cook Book—Special Sunkist Edition,"* by Alma Smith Payne and Dorothy Callahan. 480 pages, hundreds of recipes. Available now at the special price of only $1.25 *(regular edition $4.00).*

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classes frequently regret it later. My telephone sometimes rings continuously after a neighbor arrives home with her new baby. She does not know how to hold, feed, or bathe the infant, nor how to make formulas. In pre-natal classes she would have learned these simple, valuable procedures.

Here's to persuading our physicians to recommend pre-natal classes from now on.

(Mrs.) Beatrice Bomus, R.N.
The Bronx, N.Y.

## *Hours, Not Salary*

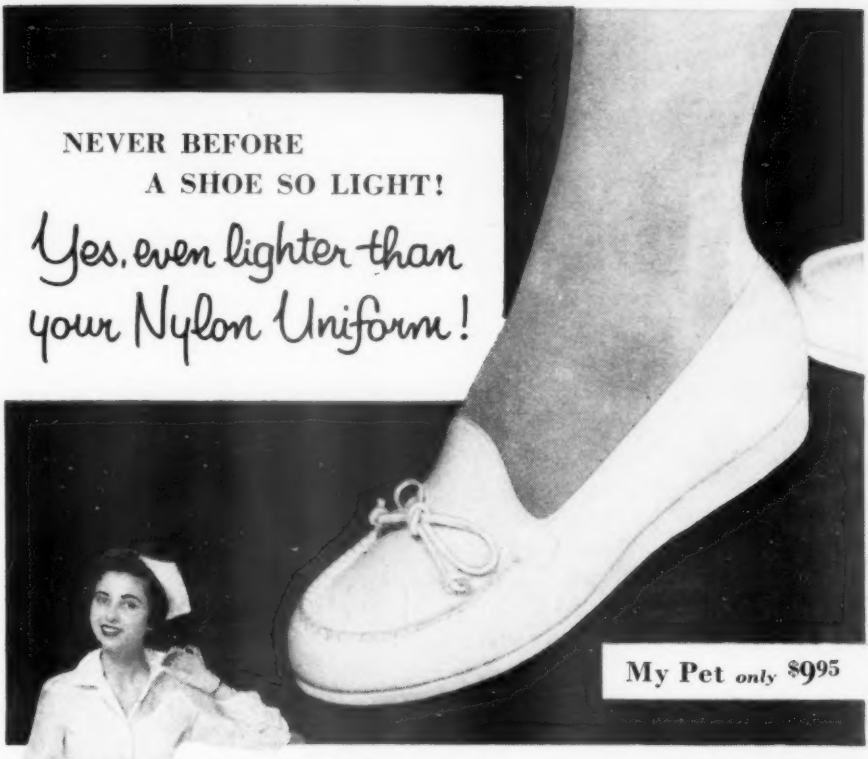
Dear Editor:

I understand Representative Frances P. Bolton of Ohio deduced from the returns to her questionnaire survey of the "critical" nursing shortage that the most critical shortage exists in general and private duty. Among the causes cited: low pay, irregular hours, competition from other jobs, length of training, tuition costs, and lastly, early marriages.

I am wondering how many married nurses there are who, like myself, would give anything to be able to work in a hospital, either on general or private duty, during hours compatible with their home lives. My personal feeling is that hospitals will not give us married nurses the break on hours which we need if we are to raise our children and march in the white parade, too. No matter how critical the nursing shortage becomes, I will not sacrifice my family, but I certainly will take with great eagerness the first nursing position

NEVER BEFORE
A SHOE SO LIGHT!

Yes, even lighter than your Nylon Uniform!



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coming my way that conforms with my family life. Because none of the hospitals in close proximity to my home can use my nursing services during the hours the members of my family are away from home, I can't work. The general reply I receive to my offers to help out is, "We are sorry we cannot use your services for the hours you specify." In all fairness to hospitals, I realize that other married nurses may be covering the hours I could work. Professionally thinking, I cannot lose sight of the fact that hospitals must embrace twenty-four hours of service, and cannot place "excess baggage" on the payrolls just because a married nurse with family responsibilities wants to work. But if this is not the case, I sometimes wonder if all the cry about "critical nursing shortage" is not in reality a fallacy.

Representative Bolton also stressed that "other" fields in nursing are luring nurses away from the bedside. I personally feel that the hours, rather than the salaries, in these other fields are the appealing factor. I am more interested in nursing than in salary, and want very much to reduce the critical nursing shortage by working a few hours a day, Mondays through Fridays during the school year. But I'm not permitted to help out! The hours presently demanded of professional nurses who do either staff or private duty nursing demand real family sacrifice, if the nurses are married.

(MRS.) KATE JANEKE, R.N.
DES PLANES, ILL.


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# Sterile Petrolatum Gauze Dressing & Packing Material

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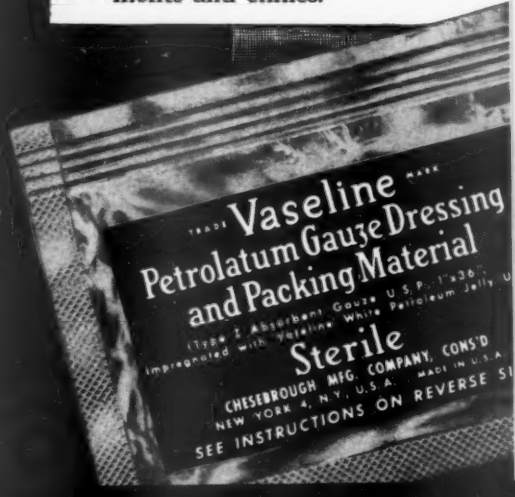


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| Urine, unincubated, control | 0.12 |
| Same urine, incubated 27 hrs. at 37°C. | 1.05 |
| Same urine, incubated with Dennison Diaper Liner for 27 hrs. at 37°C. | .19 |

*by a modification of Folin's method

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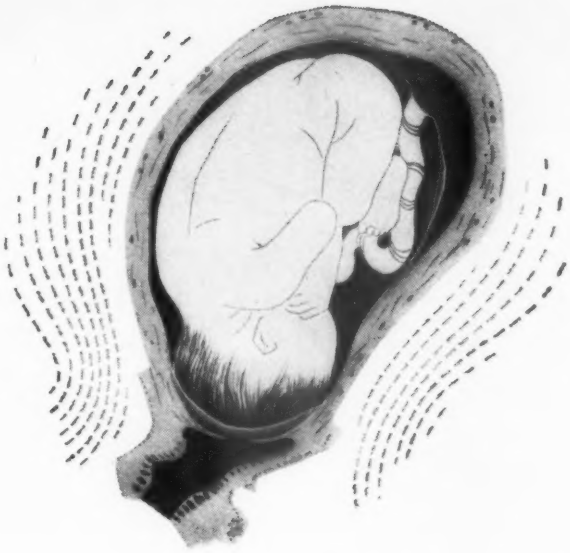
**DIAPER LINERS**



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*Kaufman, R. H.; Mendelowitz, S. M., & Ratzan, W. J.: *Am. J. Obst. & Gynec.* 65:269, 1953.

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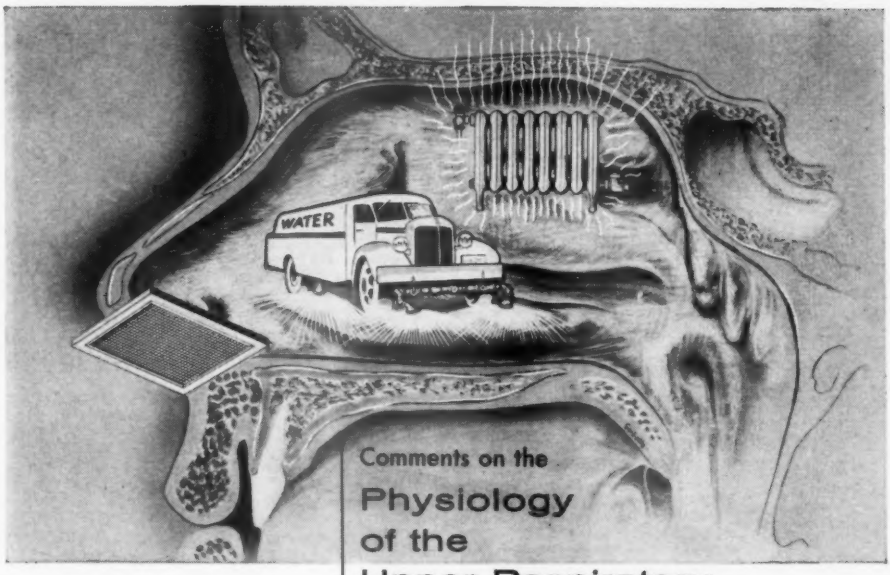


Comments on the

# Physiology of the Upper Respiratory Tract

## THE NASAL CAVITY:

The main functions of the nasal cavity are conditioning and exchanging air between the atmosphere and the lungs, as well as smelling. Gross impurities are removed by the fine nostril hairs, and finer impurities are enveloped in the mucous secretion of the intranasal lining and carried away by ciliary action. The air is warmed to a degree approaching body temperature and humidified. About 500 cc. of air are taken in during an ordinary inspiration, totaling 12,000,000 cc. daily.

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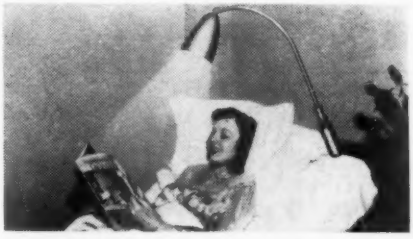
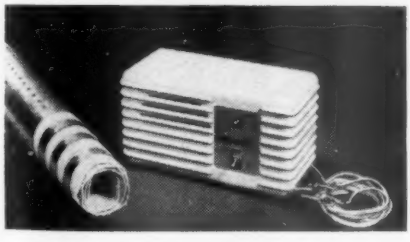
# New on the Market

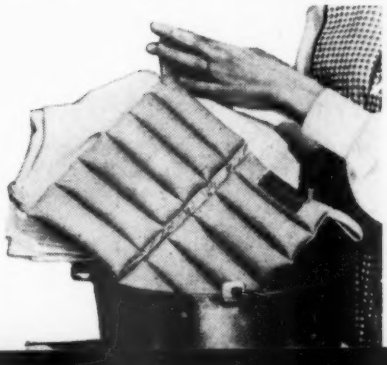


Advantages of a bed lamp and floor lamp are combined in the Nightingale No. 144 that adjusts for reading, examinations, and general illumination. Another feature is a night light, built into the clamp, which radiates from beneath the bed without disturbing the patient. The switch, within easy reach, is above the mattress along with two plug-in units and the reading light switch. The lamp is made by the Adjustable Fixture Co., 100-106 E. Mason St., Milwaukee 2, Wis.➤

➤Sit Rite, a posture-correcting Contour Seat of foam rubber, is manufactured by Chester Coleman Corp., 745 South Broadway, Los Angeles 14, Calif. For use in homes, hospitals, and rest homes, as well as for outings and sports activities, the seat is covered in brown or navy twill. There are two weights: *regular* for persons under 200 lb., and *extra* for those over 200 lb. The Sit Rite seat is $8.95; Sit Rite with Contour Back is $14.95.



➤A method of controlling nocturnal enuresis is provided by Sleep-Dri, developed by Functional Products, Inc., Warsaw, Ind. Sleep-Dri, consisting of a control unit, two flexible pads, and a yellow, absorbent washable divider, automatically awakens a child with a buzzer when urine moistens the divider, signaling him to get up. The device, powered by dry cell batteries, is not recommended for individuals with organic disorders.



Each application of the Hydrocollator Steam Pack—a fabric envelope containing a special gel filler—offers at least 30 minutes of effective moist heat. In the home, the Pack is readily heated in water in any convenient vessel; in the hospital and clinic, a supply may be maintained automatically at the proper temperature in Hydrocollator Master Units. The Steam Pack is accepted by the AMA Council on Physical Medicine and Rehabilitation, and is a product of the Chattanooga Pharmacal Co., Inc., Chattanooga 5, Tenn.➤

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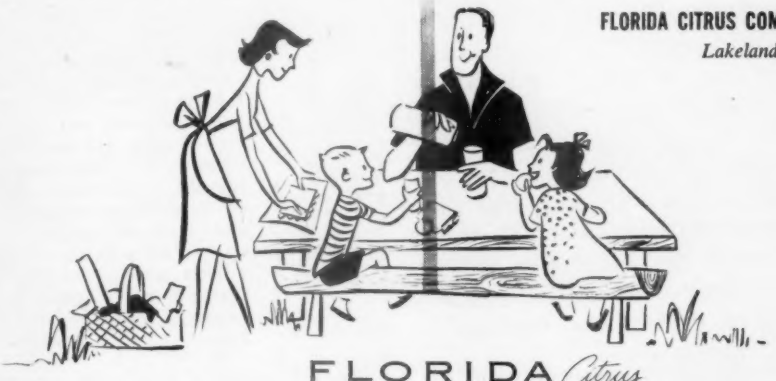
**Chick, H.: Nutrition 7:59, 1953; Cotereau, H. et al.: Nature 161:557, 1948. Jolliffe, N. et al.: Clinical Nutrition; Hoeber, New York. 1950; pp. 586-601.*



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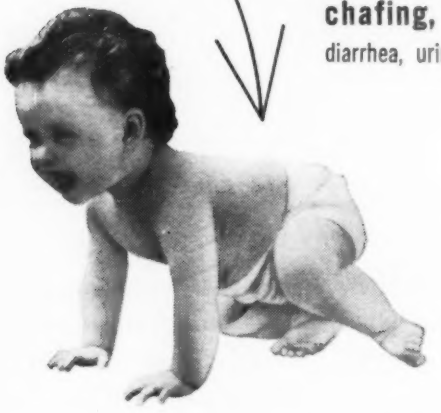
in **extensive dermatitis, diaper rash, severe intertrigo, chafing, irritation** (due to diarrhea, urine, soaked diapers, etc.)



**DESITIN OINTMENT** achieved "significant amelioration" or practically normal skin in 96¾% of infants and children suffering intense edema, excoriation, blistering, maceration, fissuring, etc. of contact dermatitis. This and other recent studies recommend Desitin Ointment as "safe, harmless, soothing, relatively antibacterial"..... protective, drying and healing.[2-4]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1. Grayzel, H. G., Helmer, C. B., and Grayzel, R. W.: New York St. J. M. 53:2233, 1953.
2. Helmer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediatrics 68:382, 1951.
3. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surgergy. 18:512, 1949.
4. Turell, R.: New York St. J. M. 50:2282, 1950.

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## *The Life or Death of District Associations*

■ ANYONE WHO HAS EVER had a house built can attest to the fact that a plausible blueprint does not always guarantee a livable house.

It would appear that there is a growing dissatisfaction with the kind of house that the profession's blueprint, the Structure Study, produced. How many of the complaints reflect the normal growing pains of a group adjusting to a different *modus operandi* or how many are premonitory symptoms of an organizational weakness we cannot know as yet.

Requests for one professional association are being heard as frequently as before the plan was voted down. Whenever declining membership figures are quoted, we hear as justification that nurses are unwilling to support two large national nursing organizations. Queries about the feasibility of continuing the ANA and NLN as nationals but combining state nurses associations and state leagues for nursing in a federation are a close runner up. It is known that some nurses gave up the proposed plan for one national nursing organization rather reluctantly; and we personally know several who have never relinquished the idea.

But the questions concerning the effects of the change on districts and the changing character of the sections are immediate and urgent. What will become of the district associations is no longer an academic query. Nurses who value the local ANA organization and who look upon it as the heart of the Association are becoming more and more alarmed as the district meetings become less frequented, as district officers and committees are bypassed more often by state and national section officers in policy considerations, and as large sections, acting cohesively, come to run the districts quite as forcefully as did some of the old alumnae groups.

Is the district still the heart of the ANA? Must the district be preserved with the complete development of sections on a district level, for the Association to survive? Or, will district associations in time become unnecessary?

The Structure Committee members obviously believed in the

# Editorial

soundness of the district as a foundation, since they retained it as such in the reorganized ANA. Many more nurses believe it is here that nurses, representing every phase of nursing activity, sit side by side at meetings, work together on committees, vote and speak on common interests. It is here where everyday personal and professional problems of the nurses are met. It is where the true "workshops" exist, with nurses from all branches exchanging experiences and views and deciding the major issues on a professional, not a specialist, basis. It is where the nurse meets with her patients, their families, and her professional allies. It is where she earns her daily bread and puts her ideas into action. It is where the roots of public opinion are embedded; therefore, the place where public relations programs begin.

These nurses believe that the development of sections in the districts, directly tied to national sections by the strongest kind of bond, economic self-interest, holds a real threat to the viability of the district associations.

In the past, ANA organizational lines were simple and direct. The ties between the nurse and the national association were on geographic lines—district, state, and national, not occupational. Earlier in ANA's existence, the alumnae associations had (not by requirement, as erroneously believed, but by gentlemen's agreement) been the entering wedge to membership. When the ANA was organized in 1896, it was around the nucleus of the Associated Alumnae of the United States and Canada. Because the alumnae associations had been so strong and faithful in organizing, it was "understood" that they would continue to be the primary unit on which the Association rested.

As time went on, and as nurses became more nomadic, certain serious disadvantages to this arose. Every alumnae association made its own policies. Some of them required nurses practicing elsewhere to pay the same dues that were paid by resident nurses *with a vote.* Some required that a nurse inactive and a [*Continued on page* 67]


Photos at Newark Beth Israel Hospital by Ernest Powell

# Radioactive Isotopes

by Althea Powers

■ UNTIL RECENTLY, radioisotopes were handled in only a few large research centers where experimentation could be carried on under optimum conditions. With the exception of radium and radon, the average nurse had little or no contact with radioactive substances. However, more and more of the smaller hospitals are now being supplied with radioisotopes, and nurses want to know how to safeguard themselves and their patients from the undesirable effects of these materials.

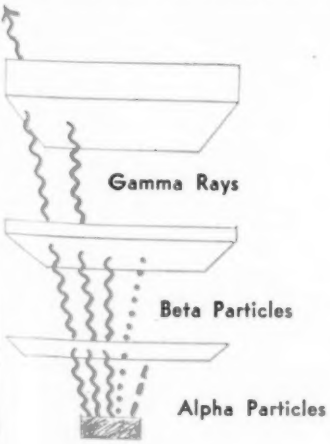
There are various levels of risk associated with radioactive isotopes but, in many instances, it would seem that the dangers have been overemphasized, at least insofar as the more common isotopes in use in the average hospital are concerned. This does not, however, mean that the nurse should adopt a foolhardy attitude in regard to radioisotopes; a respectful attitude toward the potentialities of these substances is a requisite for all who work with them.

The main clinical use of radioisotopes is in the diagnosis and treatment of malignant disease. In general, a cell is more vulnerable to radiation if it is actively growing than if it is an adult or in a relatively inactive stage, and it is upon this fact that radiotherapy of malignant disease is based. The purpose of radiotherapy is to cause maximum injury to cancer cells with minimum trauma

to normal tissue. It is not necessary that cancer cells be killed outright; it is enough that they be damaged to the extent that further cell division and proliferation become impossible.

For nurses who may not be acquainted with the language of the atomic age of nursing, isotopes are chemical elements with identical chemical behavior but distinguished by differences in atomic weights and in radioactivity. All of the 98 elements have two or more isotopes, and about 300 stable isotopes have been found occurring in natural mixtures similar to hydrogen and chlorine. The half-life of an isotope refers to the time required for half of the atoms of a radioactive element present to become disintegrated.

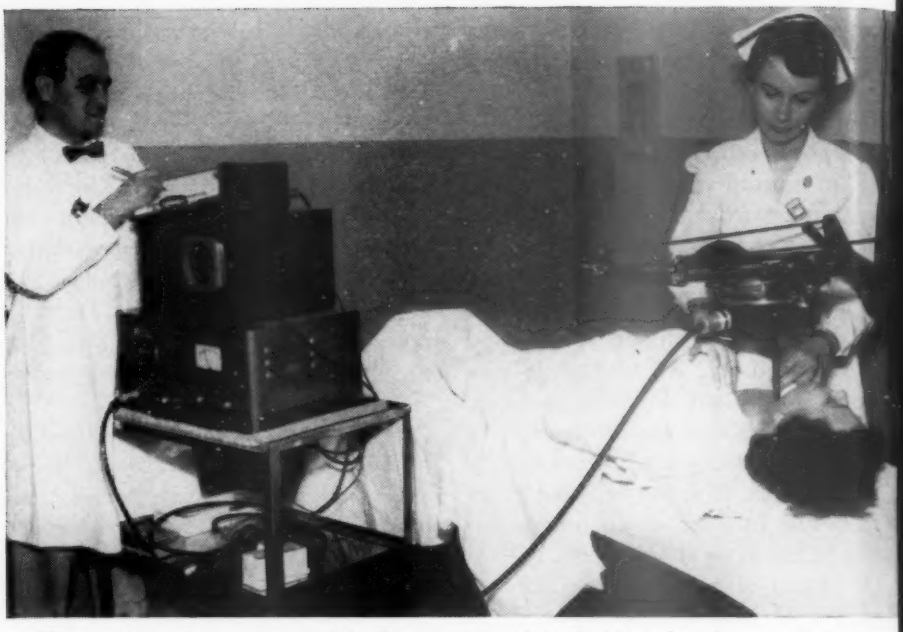
The half-life of the isotope, the type of energy emitted by the isotope, and the manner and rapidity of excretion, help to determine its effectiveness. Radioactive isotopes may emit alpha or beta particles and sometimes gamma rays. Alpha emitting isotopes are rarely, if ever, used in clinical work because alpha particles, although not very penetrating, have a high ionization ability and cause extensive cell destruction if ingested. Beta particles cause much less damage to cells if ingested. The most energetic of commonly encountered betas have a maximum tissue range of one-half inch but most betas can go less than half as far. Gamma rays, which are qualitatively similar to x-rays, are emitted with some alpha and beta particles. However, they are found with several clinically used isotopes and because of their abundance, range, and penetrating power are hazardous for personnel to encounter in *excessive* amounts. Gamma rays differ in their power of penetration; those of lesser penetration are called "soft" rays while the more penetrating rays are known as "hard" rays.




Although a great number of radioactive isotopes are utilized in research centers, only three of these are commonly encountered outside such centers. These are radioactive phosphorus (phosphorus 32), radioactive iodine (iodine 131), and radioactive gold (gold 198 or $Au^{198}$).

Phosphorus 32 may be given either orally or intravenously to persons afflicted with polycythemia vera and in certain types of leukemia where it very frequently will produce remissions. Polycythemia vera is a disease in which there is a greatly increased number of red blood cells. Phosphorus 32 emits beta particles only.

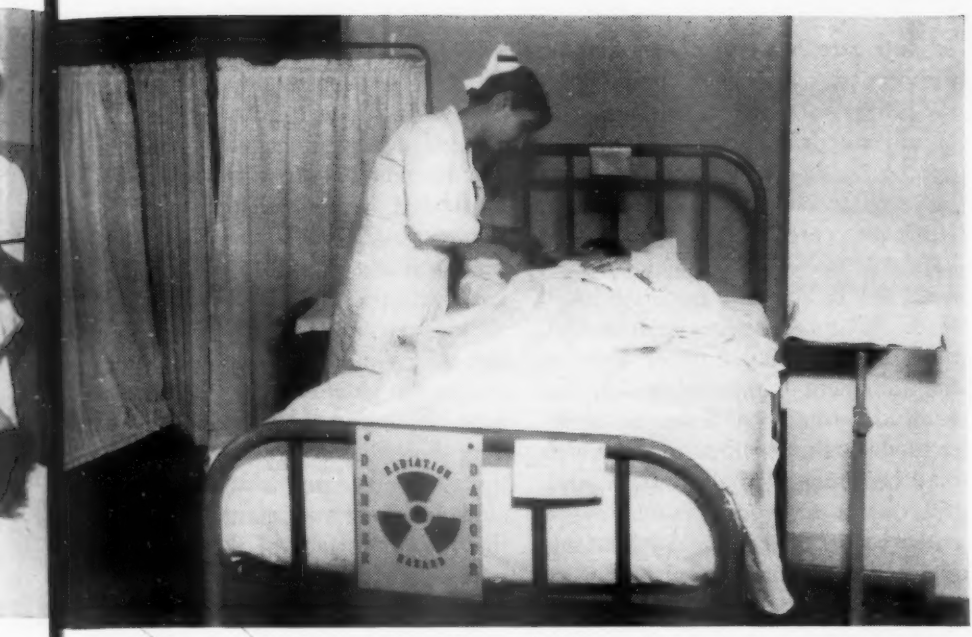
Emitting gamma rays as well as beta particles, iodine 131 serves a



**The patient shown here with the nurse and technician has been given a tracer dose of radioactive iodine to determine thyroid function.**

dual purpose. It may be utilized for either diagnostic or therapeutic reasons. In larger doses, the beta emissions exert an inhibitory effect on tissue growth, while in very small doses the gamma emissions make it possible for the diagnostician to detect abnormal thyroid function with insufficient beta radiation to affect the gland. It has long been known that iodine has a tendency to concentrate in the thyroid gland. Uptake of iodine 131 in the thyroid may be measured directly by the external use of a Geiger counter, or indirectly by measuring the total urinary excretion of radioiodine within a given time. Presumably, the difference between the amount of radioiodine given and the amount excreted is about equal to the thyroid uptake. It has been found that in hyperthyroid subjects the rate of accumulation of iodine 131 in the thyroid gland is increased, and that in myxedematous patients, the rate is decreased below the 10-35 per cent uptake of the normal person. Nurses can help physicians by assuring them of a quantitative urine collection from these patients.

Radioiodine may also be given as a means of discovering whether metastases from thyroid carcinoma are present. If thyroid metastases are present anywhere in the body, the cells concerned may also take up iodine 131, although to a lesser degree than the thyroid gland itself. The sites where the iodine 131 has




**Patients receiving radioactive gold intra-abdominally are detained until they are deemed "safe" enough to leave hospital isolation room.**

lodged can then be detected externally by Geiger counter. Doses for such purposes are usually quite small and are called tracer doses.

Because of its inhibitory effect on the cells of the thyroid gland, iodine 131 causes a gradual decrease in thyroid hyperfunction. For this reason, the drug appears to be of value therapeutically in certain selected cases of toxic goiter and hyperthyroidism. The dosage in such cases varies, but it is higher than that given for diagnostic purposes. A very high dosage of iodine 131 is given in cases of carcinoma of the thyroid. Since primary cancers of the thyroid are composed predominantly of cells not metabolizing iodine, the treatment of these lesions with iodine 131 has not been too successful. Radioiodine does, however, seem to be of use in the treatment of metastatic deposits in other areas of the body and is especially effective if the thyroid gland itself has been wholly removed.

Pleural effusion or ascites of malignant origin may be treated with gold 198. A colloidal suspension of radiogold may be injected either intrapleurally or intraperitoneally. In some instances, gold 198, which emits both beta and gamma radiation, is injected directly into the tumor mass.

Although precautions to be taken vary in connection with these isotopes, in each case they are based on certain definite principles. Excessive

exposure to radiation must be avoided and care must be taken that no radioactive material is ingested by the nurse. Fortunately, the likelihood of anyone drinking a solution containing a dangerous amount of a radioactive substance is remote. However, care must be taken that hands do not come in *direct* contact with the radioactive material itself. If the hands become contaminated, they, in turn, may transfer some of the radioactive material which has been deposited on them to cigarettes, lipstick, or other items which may be brought to the mouth, and, this means ingestion may inadvertently occur. Although the amounts ingested in this manner may be very minute, there is some danger that through repeated breaks in technique over a fairly long period of time enough radioactive material may accumulate within the body to constitute a health hazard. Since the nature of the isotope ingested, its half-life, and rate of excretion, also affect the build-up of these materials within the body, it is not likely that the nurse, whose contact with radioactive materials is relatively infrequent, will endanger herself. The fear that objects exposed to radiation (excluding neutron radiation) may become radioactive is unwarranted. Objects become radioactive only if they are physically contaminated with the radioisotope itself.

Yet, it is important that attention be paid to technique because in an area where research is being done, even infinitesimal contamination of materials with radioactive substances may give rise to far from negligible errors in the scientist's final calculations. It is expected that the nurse will wear rubber gloves if she anticipates any contact with linen or excreta which either has been contaminated with or contains radioactive material. Gloves are also a protection if there are any cuts or abrasions of the skin through which radioactive materials may be absorbed. While still on the wearer's hands, the gloves are washed for at least two minutes with soap and running water. They are removed from the hands in such a way that the clean hands are not contaminated by the outside surface of the gloves. A special container is provided for them.

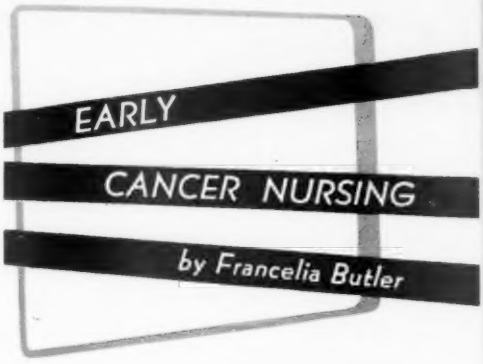
The best protective measures against radiation are common sense and a knowledge of the precautions necessary in each particular case. However, it is the responsibility of the radiation safety officer of the hospital to provide instruction for other personnel if they are to avoid over-exposure. The nearer one comes to the source of radiation, the greater the amount of radiation to which one is exposed. This is in compliance with the Inverse Square Law which states that the intensity of radiation varies inversely as the *square* of the distance from the source. For example, a nurse four feet from the source of radiation will receive only 1/16 as much radiation as would a nurse only one foot away.

Radioactivity also lessens as time goes by. For example, the half-life of gold 198 is 2.69 days. This means

that the amount of radiation coming from the gold at the end of 2.69 days is only one-half of what it was at the beginning. The half-life of carbon is 5,740 years, while the half-life of iodine is 8.0 days. If the bulk of the drug is excreted fairly rapidly, as is radioiodine, the amount of radiation will be proportionately diminished as the amount of radioactive material contained within the patient is reduced. The nurse who comes into contact with the patient only occasionally may safely be exposed to a larger amount of radiation at one time than may the nurse who is in constant attendance upon the patient.

The beds of patients receiving radioactive materials are tagged with the name of the isotope given, dose, time, and date of administration. This is primarily for the purpose of warning laboratory and x-ray technicians that a source of radioactivity is present. If an x-ray technician were to unwittingly lean a cassette against the foot of the bed in which there was a patient receiving a radioactive material, he might find that the film became cloudy; film is very sensitive to radiation. This is the principle behind the film badges which are so often worn by those who work in close proximity to radioactive material.

These badges are erroneously called "shields" by some nurses. Actually, they have no direct protective value, but are used as a means of gauging whether a person has been exposed to too large an amount of radiation. [*Continued on page* 70]




■ AMERICAN HOSPITALS of the nineteenth century generally were not admitting cancer patients, partly because cancer was then regarded as an incurable disease, and partly because a stigma was attached to the disease, for many people believed cancer to be contagious and quite possibly of venereal origin.

The first annual report (1884) of the New York Skin and Cancer Hospital (now part of the New York University–Bellevue Hospital Medical Center) stated:

"Patients suffering from cancer have never been welcome in any hospital in this city; in most institutions, they are absolutely refused, and nowhere in this country have cancer cases been grouped together with a view of studying the disease as to its nature and cure. Some cancer cases are received with other diseases at the Home for Incurables in Fordham, and pauper cases at the Hospital for Incurables on Blackwell's Island; but in neither do they enter with a view of treatment but

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Free-lance author Butler hopes to publish a history of cancer eventually.

only to await termination of life by their dire malady."

When America's first all-cancer hospital (now known as the Memorial Center for Cancer and Allied Diseases) was established in New York in May, 1884, the stigma attached to the disease was transferred to those who nursed it, and nurses often found themselves shunned by members of the public, very much as if they had smallpox.

Nevertheless, by 1893, a post-graduate nursing school was established at Memorial. Screened from the view of the public by the board fence which surrounded the hospital lawns, the nurses played croquet when not on duty, or, in inclement weather, studied the skeleton given them by one of the doctors, and the weighty medical books with which the doctors had equipped the nurses' library.

After three months of preparation in the nursing of cancer patients at Memorial Hospital, Rose Hawthorne Lathrop, gently-reared daughter of Nathaniel Hawthorne, founded the first cancer home for incurables in a tiny flat on New York's lower East Side. She became a Roman Catholic, and later, with her friend, Alice Huber, organized the Servants of Relief for Incurable Cancer, which in 1899 opened the St. Rose's Free Home for Incurable Cancer, in New York. Two years later, a building at Sherman Park, now Hawthorne, New York, was acquired, where the work was carried on under the name of Rosary Hill Home. Among the first to recognize and praise the quality of its cancer care was Mark Twain.

With the coming of radium therapy, cancer nurses encountered a new hazard. Before the development of protective measures such as leaded rubber gloves and shielded forceps for picking up the tubes, many nurses risked their lives in the treatment of cancer patients. It was their duty to attach radium applications as indicated by previously-placed marks on the skin and, as there was then no knowledge of the cumulative effects of the rays, they often handled the radium applications with their bare hands. As a result, several of them died of lymphatic leukemia. Such tragedies hastened the development and adoption of protective devices. Now cancer nurses are experienced in working with radium and with the newer radioactive substances—the radioisotopes—as well, and they do so in comparative safety, partly because of knowledge gained during those first pioneer years of experimentation.

Much progress has been made in cancer nursing since those early days. Centers for the diagnosis and treatment of cancer have been set up throughout the country. Members of the medical profession and the public itself are facing the problem of cancer with less panic and with more knowledge than ever before. Nurses who wish to specialize in cancer nursing may take advantage of the post-graduate and in-service program offered by some of these centers. Some of these courses are affiliated with universities. Films and pamphlets on can- [*Continued on page* 76]

## CANDID COMMENTS: *The Fallacy of Forecast*

■ MALTHUS, English political economist of the nineteenth century, held that unless the world's population were restricted it would eventually outdistance the world's food supply. His ideas were widely accepted. Now, more than 100 years later, comes the report that for the second year in succession the gain in the world's food supply has outstripped gains in population. In the late 1930's, a consistently falling birth rate led U.S. authorities to predict that by 1970 our population would become static, and even begin to decline. But our bumper crop of babies in the last ten years has blown that prediction into oblivion. Today the lack of school rooms and teachers is a critical problem.

*Janet M. Geister*

In the prosperity years of 1927-29, before the stock market crash, there was serious unemployment among nurses. The production of nurses far exceeded the consumption of nursing skills. People were buying many more *things* but not more nursing service. The economic depression accentuated and prolonged nurse unemployment. In July, 1932, our three leading national nursing associations sent a letter to all hospital superintendents pleading for a cut in nursing students and schools: "Thousands of nurses are unemployed . . . We had too many even before the depression set in." All of us who were speaking for nursing were crying: "Overproduction! Cut down. At this rate we'll be overwhelmed within a few years." Just 20 years ago—in 1934—that was still the theme.

There is no need to elaborate on the reversed condition today; it is too obvious. My reasons for citing these contrasts between forecast and actual events are, first, to indicate that predictions of this nature can be made only on the basis of prevailing conditions. The tomorrow is still unknown, and science, education, new health hungers, and wars can change the scene almost overnight. Second, to point out that preoccupation with neat charts that show present and future needs, can divert us from getting the best out of the forces we have at hand *now*. It seems futile to keep our minds on the numbers we lack today and on the "fifty to sixty-five thousand" we will need tomorrow, unless we give just as much thought to providing every qualified graduate and student nurse the opportunity and environment to bring out her best. Readying all nurses for tomorrow is just as important as multiplying them.

It is true that in 1930 our supply of nursing greatly outran the de-

mand. But mighty changes were at the threshold. Prepaid hospital care was just about to be tried out. Science was just introducing the "miracle drugs" and appliances that revolutionized "styles" in sickness and its treatment. The whole emphasis in the previous decades had been on the *beginnings* of life. "Save 100,000 babies" was the battle cry of the U.S. Childrens' Bureau 1918-1919 campaign. Older patients received palliative, but not generally the corrective and rehabilitative care that is being advocated today. Our people were still holding their breath over the astonishing drops in communicable disease, and infant and maternal mortality, brought by the sweep of the early public health movement. They were not yet demanding equal care for all people, for all health needs, "from the cradle to the grave."

Student nurses gave most of the patient care. In 1929-30 we estimated that not more than 3,000 graduate nurses were on general duty. In 1953, according to *Facts About Nursing*, 112,324 graduates were on full-time general duty; 29,721 more were on part time; and almost 59,000 more were in supervisory and head nurse positions.

In 1934, before our present broad gauge health programs were under way and before nursing was generally recognized as a vital component of every health venture, no one could foresee what lay ahead. In the next 20 years public health, industrial, office, school, clinic nursing came into full flower. Many thousands of new supervisory and teaching positions were established. With the stress on early ambulation and shorter hospital stays came a greater concentration of care that demanded more and more skilled nursing.

In 20 years, the 1934 scene was almost directly reversed. The 1934 forecasts were based on the health customs, environments, and philosophy of that day. Our 1954 forecasts must follow the same pattern—yet who knows even approximately, how much and what kinds of nursing we will need? No scientific field changes more rapidly or vividly than medicine. Only today comes the news from the American Association for the Advancement of Science of a discovery "that holds almost limitless potentialities for the health of mankind." Dr. Louis Pillemer of Western Reserve University has isolated the natural blood chemical "which destroys bacteria, neutralizes viruses, and gives the animal body an innate immunity to hosts of would-be-invaders." Statistics are a most valuable tool, but one with no more imagination or prescience than any other inanimate object, and to me it seems fantastic to rely upon them too greatly for forecasts of what is to be.

On the basis of my long experience and observation I feel sure of but one thing—we will need all the nurses we can get. Our population and world hungers are growing; nursing is intrinsically an essential element in all health movements; new, attractive careers in other fields offer a toughening competition for

recruits. I cannot believe that any part of the 1934 unemployment crisis will repeat itself—rather, I expect the contrary. We will be put to it to use the available supply of nurses to the greatest advantage.

We need, therefore, to be done with this obsession with numbers. We need to obsess ourselves more profoundly with bettering today. While many enlightened employers of nurses and nursing administrators are working valiantly and intelligently toward better personnel practices, better human relations, better use of nursing service, too many unenlightened ones make "shortages" a whipping boy, an alibi. They feel they have done what is needed by simply adding more helpers. The result too often is only chaos.

In this common obsession with numbers we hear more, for example, about building more and still more hospitals than we do about screening the applications and admitting only those in need of hospital care. We hear more about how many sick people there are than we do about the program for [*Continued on page* 63]

● Alone and frightened in the huge, white hospital room, tiny four-year-old Lorraine wondered why daddy and mommy had gone away and left her. Didn't they want her any longer? Strangers came and talked to each other in front of her using long, mystifying words like "handicap," "coordination," and "cerebral palsy." It was a long time before she could leave the hospital, and when her parents finally came for her, Lorraine had withdrawn into her own private world. She distrusted everyone and had little to say to anyone until the day came when she went off to school.

It wasn't easy at first, but gradually P.S. 135 became her world. There were children there like herself and she felt that everyone was interested in her and truly cared about her. Each morning the children recited the pledge to the flag which the teacher taught them. The pledge and her teacher's kindness to her stood out in Lorraine's mind as symbols of all that Lorraine found good and joyful at the school.

One evening her mother, listening to Lorraine's prayers, heard this:

"Dear God, I pledge allegiance to the United States and Miss Haeussermann of America and bless mommy and daddy and brother and for which it stands; now I lay me down to sleep, for liberty and justice for all my soul to keep. Amen."

Excerpt from "The Little Twigs" column by Estelle Marks, appearing monthly in the Cerebral Palsy NEWS, published by United Cerebral Palsy of New York City, Inc.

# Authoritarianism in

■ PERHAPS IT IS because I have now willed the serious continuance of nursing to others that I can treat it more lightly than when I participated in the pressure of nursing service and nursing education—when the hospital administrator limited the school of nursing budget and the state board insisted upon more spending, and I was caught in a vise.

I was a nurse for thirty-three years; twenty of those years were spent in administrative positions in hospital schools of nursing. Perhaps it is the fatigue of one no longer young, but I wonder if nursing has learned much from its great adventure, which began as an expression of friendliness and concern for others—a genuine brotherly love, which has always been rare in the world. Until authoritarianism crept into nursing it had the ability to meet new problems with new solutions; there was little to fear and no excuse to hate. In good faith and complete sincerity nurses helped those who were unable to help themselves.

The first symptoms of authoritarianism were not recognized as a dreaded disease until many of the nursing schools had become infected. The authoritarian believed in the principle of subordinating individual freedom to the rules of authority. Some of the hurdles taken or circumvented during the long years that authoritarianism was "in the chair" had little to do with nursing as such.

During the twenties it was slowly discovered that one could be a good nurse even though one used rouge on the cheeks to brighten the smile given to patients. The thirties removed the fear of being dismissed if you were a student, or of not being accepted if a candidate, for having bobbed hair. The forties eliminated most of the penalties for wearing lipstick or fingernail polish. The fifties are reducing the limitations upon smoking, and marriage in nursing. Even the pregnant nurse now has uniforms designed for her comfort and appearance. (Unfortunately, in the past year I have heard authoritarians become as emotional over the fact that a student wore her new diamond ring while in uniform, as one would expect them to be over the disloyalty of a friend.)

While these minor outward symptoms of this disease, authoritarianism, were being slowly but successfully treated, another phase of the illness grew ever deeper into nursing proper. It was authoritarianism in the form of ready-made opinions, philosophies, and judgments for nursing as a whole, for schools of nursing in particular.

Some of the experts, desirous of evolving a tightly-knit curriculum that would produce a disciplined body of nurses for the world, be-

came authoritative sources for changing traditions. Unfortunately, nurses, like most people, wanted the answers. So conscientious and insistent were the experts that constant listening to the answers made many nurses forget to ask questions, forget to reflect upon what the questions were in many instances.

Fortunately, today, it would seem, this authority is beginning to give way in some areas of nursing. But the authoritarians prepared us well

quire?" and "What does the League recommend?"

That there is genuine need for authority in some areas of nursing we cannot deny. There must be a place for authority to make decisions and enforce them in such matters as safe nursing care for the public, which involves examinations and licensure. If one does not approve of a decision, the sensible thing is to work for its change.

There are also well-founded prin-

## in nursing

by Franceska Rich

for intellectual humility. Those of us who were not stubborn in our convictions became hypocrites. We often conformed outwardly, while our minds remained unconvinced. We said we did not subscribe to an authoritarian idea or we apologized for having carried out its spirit; we hid our feelings about such things as giving the practical nurse the status due her to insure a higher calibre of women being attracted to take up the work. We appointed inexperienced nurses with degrees to faculty positions that an experienced degreeless nurse could have filled more advantageously. Many nurses have become so hardened to authoritarianism that they no longer object to it. This placidity is symbolized by "What does the state board re-

ciples it would be nonsense to deny or change. We accept certain established facts, but we also maintain that when they are found to be groundless, we should discard them.

No individuals in the past have discovered the final truths once and for all time to come. There are experts in chemistry, anatomy, microbiology. There are no experts in standardized opinions, and judgments of what is right and wrong in nursing cannot be provided by one group or one organization for all time and all areas. Some ideas are sacred, some have the prestige of tradition, but some are only the ideas of those who hold positions of authority at the moment, or held them in the past.

All this is only the preamble to

set the course for a few paragraphs on what, in my humble opinion, the nurses of today are trying to do to remedy the situation.

It appears that some of the more democratic experts have become and want individual nurses in local areas to become innovators—that they may discover, not what is right for the future so much as what is wrong with the present in nursing.

These present-day leaders, who have replaced the "absolute monarchs in well-insulated offices," are dissatisfied with things as they are. These individuals see problems which their predecessors did not see. They seem to realize that a few powerful nurses cannot determine the judgments of truth and falsity, of good and bad, for nurses as a whole. While alive, they may be called radical and uncooperative but they are aware, it seems to me, that the real issues are far broader and potentially more inspiring than those that the authoritarians have argued over so mightily in the past.

What is it these present-day leaders wish for nursing? Please note that I used the word "wish" and not "plan." Some will wrongly call this the confusion of the intellectuals. I think it reveals a comprehension of how wrongly placed authority, compulsion, and autocratic measures can warp ideals and create a sense of frustration.

With the utmost humility we must admit we find nursing in a crisis, large and complicated. The fact that there are comparatively too many patients and too few nurses is the

# Science Shorts

**Some 1,000 convicts at Stateville Penitentiary in Illinois have volunteered as "guinea pigs" in a research experiment designed to solve the mystery of the common cold, and to determine whether it is possible to develop immunity to colds. The one-year investigation, which will be financed by the army, is to be carried out by a research team of University of Illinois doctors and scientists.**

■

***A study of air pollution, including vapors, gases, droplets, spores, pollen grains, bacteria, and radioactive particles, is planned under a new federal environmental sanitation program.***

■

**More than 80 diseases, or "zoonoses," can be transmitted to man by domestic or wild animals, is the report of a recent monograph published by WHO. Among the zoonoses—diseases of animals transmitted to man—are bovine tuberculosis, brucellosis, Q-fever, rabies, and leptospirosis. The latter disease is said to affect butchers, millers, farmers, and also owners of pets (dogs).**

■

***A new TV complication is reported by the British Dental Association. It seems that children have the habit of watching television with their heads held in their hands. When they get excited, they press their hands harder and harder, causing teeth to go out of proper alignment.***

■

**The tropical disease, yaws, once the number one public health problem of Haiti, has almost been eradicated in that country through the widespread use of penicillin. Help in the yaws campaign, that began in 1950, came from the Haitian government, cooperating with the Pan American Sanitary Bureau, WHO, and the United Nations Childrens Fund.**

outstanding reason for the lack of satisfaction of achievement in nursing, but there are many other reasons why pressure, tension, and frustration are so common in hospitals and schools of nursing.

Merely repeating the solutions of the past will not provide the individual nurse with an understanding of her responsibility in this crisis. Even before we are members of an organization, of a faculty, or on a staff, we are human beings. As individual nurses, we are confronted with a challenge so great as to dwarf by comparison the issues and problems that exist within or between nursing organizations. Our new leaders seem to know this.

The nurse without some insight into the present day dilemma of nursing is quite likely to be nursing in a perfunctory manner and there is little satisfaction in what she does. If nurses are happy—that is, successful and satisfied—nursing will attract more nurses. The process starts with us and returns to us—the individual nurse.

Individual nurses *who think* are important in a way that no organization or institution can be important. Now that the theorists have had their say, nursing still remains in the hands of nurses. If the individual nurse has doubts and conflicts, this should challenge her to find a philosophy of life and of nursing. It is never too early or too late for the nurse to evaluate her practice and procedures.

Organizations and boards of directors may [*Continued on page* 74]

**Social class rather than the age of the mother appears to be a greater factor in the health of the baby, according to a study made by Drs. Dugald Baird and James Walker of the University of Aberdeen, Scotland. The combined stillbirth and first-week-of-life-death rate was 24 for each 1,000 among women of the highest social class, and 44.6 for women in the lowest social groups.**

■

***Time-motion studies made at Wayne University in Michigan, and sponsored by the Michigan Heart Association, show that 75 per cent of a housewife's walking, bending, and lifting are avoidable.***

■

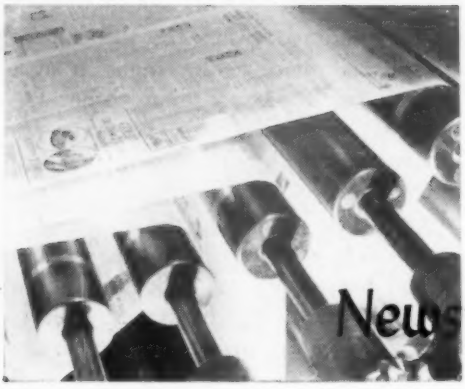
**Bed rest, daily exercise of the affected joints, heat, and aspirin contributed more toward improving the crippling condition of rheumatoid arthritis than modern hormonal therapy, according to the *Bulletin on Rheumatic Diseases*. In a two and one-half year study, substantial improvement in the condition of 200 out of 282 patients resulted from "conservative" treatment plus the use of aspirin.**

■

***Victims of heart disease who recover from an initial attack have a good chance of living for many years, say Metropolitan Life Insurance Company statisticians. A study revealed that 70 per cent of a group disabled by heart disease were still alive after a period of five years.***

■

**Dizziness and vertigo are differentiated by Dr. Vince Mosely in the *Journal of the South Carolina Medical Association*. Dr. Mosely states that vertigo is a subjective sensation of whirling in relation to the environment. Dizziness is a subjective sense of unsteadiness without sensation of environmental change, but with dulling of perception and thought.**



# News in Review

▶ *ANA'S VICE-PRESIDENT*, Mrs. Lillian B. Patterson, died on September 8, 1954. At the time of her death, Mrs. Patterson was dean of the University of Washington School of Nursing. Active in state as well as national affairs, she also served as SNA board member and president of the Washington State Nurses Association.

▶ *EXPERIMENTAL PROGRAMS:* Rutgers University and Fairleigh Dickinson College, participants in N. J.'s nursing education pilot studies, graduated their first classes this past summer. At Rutgers, five young women successfully completed a concentrated twenty-four month course, including academic study at Rutgers Newark College of Arts and Sciences, as well as practical work in affiliated hospitals. The first graduates of the shortened university curriculum, they received the first Associate in Science degree certificates to be awarded in Rutgers' 188-year history. The sixteen students who were graduated from the two-year course at Fairleigh Dickinson received the Associate in Arts Degree . . . A new program starting at the De Paul Hospital School of Nursing, Norfolk, Va., this fall, condenses the usual three-year program into two and one-half years to make room for a six-month internship in surgical and medical nursing at the hospital, prior to the granting of a diploma. According to Sister Aloysia, director of the school, the plan will put the two and one-half year educational period on a higher plane; it will in no way reduce the hours of classroom lecture or clinical instruction previously given in the three-year program.

▶ *CHARGING UNFAIR LABOR PRACTICE*, the Pennsylvania State Nurses Association has filed a protest with the state's Labor Relations Board for the firing of a nurse who acted as a spokesman for staff nurses involved in a hospital personnel problem. The Association's action followed its failure to have the nurse re-employed voluntarily. PSNA's attorney has filed a brief with the Labor Relations Board supporting the stand that non-profit hospitals are subject to Pennsylvania's labor laws.

▶ *A SUIT WAS WON* by St. Petersburg nurses in contesting the validity of an occupational license tax which the tax collector of

Pinellas County tried to collect from the County's private duty nurses. After hearing testimony on both sides of the case that was brought by Dorothy Mullans, R.N., on behalf of District 13, Florida State Nurses Association, the Circuit Judge stated that "It is ordered, adjudged and decreed that it is the opinion and decree of this Court that registered nurses as such are not subject to an occupational license tax for the County of Pinellas and State of Florida, regardless of which or in which category they may fall in relation to their present duties." The suit was instituted with the approval of the FSNA Board of Directors, and financial assistance was given the District during its court battle.

▶ *MISSOURI'S LPN's*, following the lead of the state's R.N.'s now wear a patented identifying emblem. Worn on the sleeve, the embroidered insignia includes the letters L.P.N. and the state name and current licensure date. Adoption of a uniform insignia for licensed practical nurses in all states was advocated at the National Association of Practical Nurse Education convention in San Antonio, Tex., in April of this year and, as a result, the new emblem is currently under consideration in many other states.

▶ *CAPITOL COPY:* Before adjourning on August 20, the Eighty-third Congress passed a compromise bill increasing social security benefits and taxes to bring an estimated 10 million more persons (mostly farmers) into the old-age benefits program. Thus, 58 million Americans are now covered by social security. Doctors and dentists are still excluded. The increases in benefits average $6 a month. To help meet them, the 2 per cent payroll tax now based on the first $3,600 of salary has been extended, effective January 1, 1955, to the first $4,200 of salary. Workers who pay the higher tax will eventually receive higher benefits, however. Maximum benefit for the single worker at present time (including recent increase) is $98.50. For the single worker who retires in future years [*Continued on page* 79]

## About People

▶ ***DR. MARTHA ELIZABETH ROGERS,*** **former research fellow at the Johns Hopkins University, has been appointed chairman of the department of nurse education in New York University's School of Education. She succeeds *DR. VERA S. FRY* who has joined the staff of the School of Public Health Nursing at the University of California, Berkeley . . . The VA's highest award, the Exceptional Service Award, has been presented to *MISS MARIE BROPHY,* who retired as chief of the nursing service at the Denver VA hospital after thirty-three years of nursing service for the government. Miss Brophy was the first VA nurse to be elected to the presidency of a state nursing association, and she is the second nurse to receive the award. *MISS MARY JANE McCARTHY,* former assistant chief, succeeds her . . . Maj. Gen. George E. Armstrong, Surgeon General of the Army, recently administered the ANC oath of office to *JANE LEE* and *JOAN LOUISE WILLIAMS* of Arlington, Va., the twin daughters of Army Colonel Louis F. Williams and graduates of the Johns Hopkins Hospital School of Nursing . . . *MISS JESSIE NORELIUS* has retired as executive director of the Iowa SNA, a post she held for eight years. She is succeeded by *MISS ELIZABETH BUSCH,* assistant executive director.**


# CLIMATE: It can kill or cure you!

■ MOST OF US KNOW from personal experience that the way we feel and act is often influenced by the weather. Few of us, for example, fail to react to a bright, sunny day—or to a dark, dreary one. Some of us, who suffer from arthritis or other chronic diseases, may even be aware, to our sorrow, that day to day changes in the canopy of air under which we live can cause alterations in our joints and organs. But what most of us don't realize is that, far from being limited to a few isolated phenomena obvious to all of us, our response to weather has been studied scientifically. And the science—meteorobiology or medical meteorology—is full of facts of profound significance to human health and welfare.


That weather, season, and climate are factors as important to our well-being as heredity and diet is indicated by much of the amazing material uncovered by recent research on what weather does to us from "womb to tomb." For example, there is now evidence that the month and season in which a child is conceived may determine not only his health and longevity, but also the status he will attain in life.

At life's other extreme, weather works to hasten the demise of many aged and ill persons, whose bodies are unable to bear the stress imposed by a harsh atmospheric environment. While weather doesn't often cause disease directly, it is very frequently the factor that tips a precariously held balance.

Statistics show that all through life, weather has startling effects on every aspect of human behavior. Teachers know that children are most unruly and difficult to control just before a storm. At the same time, there is an increase in accidents in the factory, at home, and in traffic. Police department records show rising rates of drunkenness, disorderly conduct, and crimes of violence, when winds blow hot. And a study of history reveals a pattern of events that follows a corresponding pattern in the world's weather. The fact that we seem to be at present in a period

of rising earth temperatures is causing much speculation in some scientific circles concerning the possible long-range effects on human conduct and world history.

Nurses and doctors, however, are more concerned with how they can put into practice the newer knowledge of weather biology, in ways that will increase the safety and comfort of the patients in their care. And, it is certainly true that an under-


by Morton J. Rodman

standing of the physiological effects of climate is essential in the treatment of many illnesses, even though climate therapy alone is not a substitute for other medical measures.

Among the many ways in which weather influences physiological functions, two features are of outstanding importance. These are, first, the extent to which environmental temperatures facilitate or interfere with the loss of heat produced by the bodily machine, and, second, the degree to which sudden changes in temperature, barometric pressure, and humidity interfere with normal body functions.

To appreciate the far-reaching effects of temperature on such basic biological functions as conception, growth, the attainment of sexual maturity, and resistance to infection, it is useful to remember that the human body resembles an internal combustion engine. Like such an engine it burns fuel (food) to produce energy, and much of this energy is waste heat that must be disposed of. When the body's system is capable of accomplishing the job of heat loss easily, growth is most rapid, maturity comes early, resistance to infection is high, and energy is abundant.

When, on the other hand, the disposal of waste heat is made difficult by prolonged high environmental temperatures, it is believed that the body responds by lowering its rate of combustion in order to produce a minimum of heat. Inevitably, however, this leads to a general slowing down of various vital life processes including growth, working performance, tissue repair, and the building of barriers against infectious organisms.

The tropics are a living laboratory

for testing these theories. There, children generally grow slowly, mature rather late, and attain relatively small size as adults. Contrary to popular opinion, the onset of the menses and of reproductive fertility occurs much later in girls living in the tropics than among those growing up in cooler climates.

The greater incidence of infection and the higher death rate from infectious disease in the tropics are said to be due, in part, to lowered resistance resulting from the body's attempt to bank its own vital fires as a defense against the heat. While the danger of infection is also increased by indirect climatic influences offering optimal conditions for growth of micro-organisms and their insect vectors, there is ample evidence that debilitating heat lowers tissue vitality. As a result, people are more vulnerable to invasion by bacteria and parasites and they are also less able to fight the diseases these produce.

Digestive diseases, for example, are said to be more common in the tropics and in summer heat, not merely because of poor sanitary controls, but because of actual physical factors that lower resistance. In high heat, the body's blood tends to pass from the interior to the periphery in order to increase the loss of body heat, with the result that fewer leucocytes are left in the gastro-intestinal tissues to repel invading organisms. In any case, it has been found that extreme heat reduces the fighting power of these white blood cells as well as the body's ability to produce needed immune antibodies.

The same swings in weather that tend to toughen and stimulate the sturdy are a source of stress for those who are in any way weakened by age or physical disability. Despite the generally greater resistance of people who live in cooler climates that allow easy loss of body heat, certain conditions including respiratory infections and a wide variety of degenerative diseases, metabolic imbalances, and mental disturbances take their heaviest toll in these regions. These illnesses are the result mainly of the second climatic factor mentioned earlier—the sudden atmospheric changes that occur constantly in the temperate zone, and especially the storminess of the Northern winters.

Various diseases are more deadly in hot weather and in hot climates which lower the victim's resistance and vitality. Thus, tuberculosis patients with arrested cases are warned to stay away from regions of tropical and subtropical heat, lest they suffer a flare-up of the infection. It has also been noted that TB hits harder *and* runs a more rapid course in people born and brought up in the South. Appendicitis also has a much higher death rate in summer and in the South, although the greatest number of cases occurs during the Northern winter.

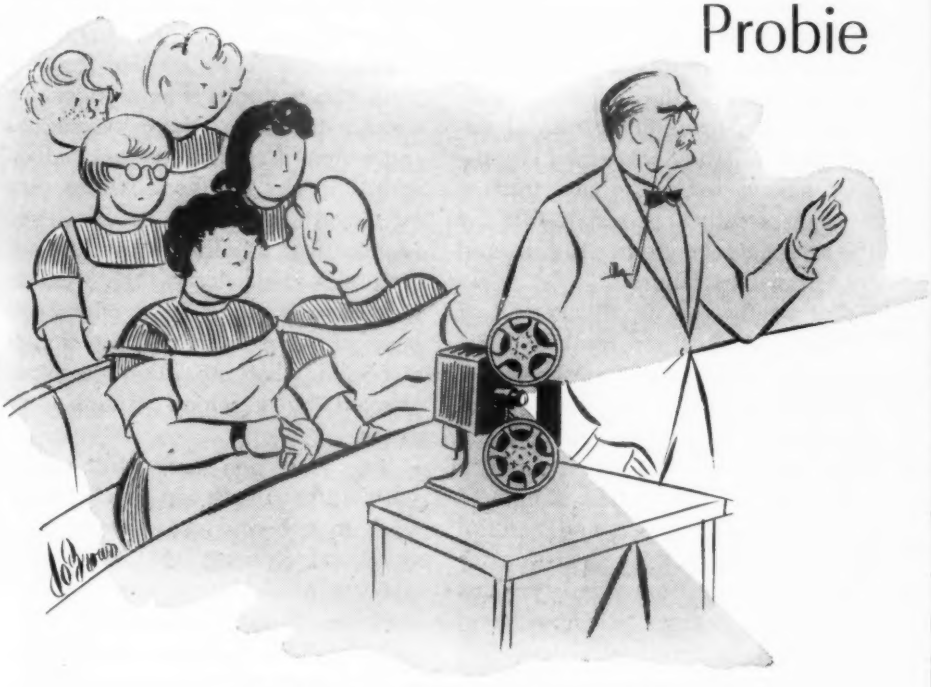
Many mechanisms have been suggested to account for the way that weather precipitates acute attacks of dozens of different diseases. Temperature, barometric pressure, and relative humidity play the most import-

ant roles, and it is thought that in one way or another they may interfere with cellular oxidation and hydration. Certainly, tissue anoxia can do injury to various vital organs, especially the brain and the heart. Such "air hunger" might put an extra burden on weak spots, and might well be a fundamental factor in failure of circulation, for example.

The physiological mechanisms that adjust the body's blood supply to meet the ever-changing requirements of the various organs must stay in action constantly, and anything that interferes with their functioning will result in discomfort or illness. A familiar example of the physical effects felt when such circulatory adjustments lag is the set of signs and symptoms known as "spring fever." That lazy, listless feeling is not a figment of the imagination alone.

The "spring fever" syndrome stems from the body's efforts to acclimatize itself to a sudden shift from wintry weather to the warmth of early spring, at a time when the body's heat production thermostat is still set for winter. The circulatory mechanisms for heat loss have to work overtime to carry excess internal heat to the surface. Water for the body's radiator passes from the cells and tissues into the blood, more plasma is produced, and the arteries dilate to accommodate this extra fluid. It

## Probie



"What did you expect—cinerama?"

takes longer, however, for the body to build up the red blood cells needed to balance the increased plasma production, and it is this dilution or "thinning" of the blood that accounts for the lack of pep and ambition that besets us for the first few days of warm weather at winter's end.

Much worse than such minor discomfort, though, is the danger of a sudden severe cold spell, following close on the heels of such a period of warmth. Such cold causes the arterioles to constrict on the circulating blood, the volume of which may have been increased by about one quart during the presence of the warm front. The resulting increase in blood pressure may cause congestive heart failure if the myocardium is weak, or lead to cerebral hemorrhage if the capillaries are fragile. The stress and strain of adjusting an already weakened circulatory system to such sharp fluctuations in weather is responsible for the seasonal increase in death caused by circulatory failure.

Yet deaths due to the impact of adverse weather on weakened organs are for the most part preventable. Climate therapy tailored to the specific needs of patients afflicted with a wide variety of ailments can add years of life, when combined with proper rest, diet, and medical treatment. This is true, especially, for elderly sufferers from circulatory disorders and younger people plagued by chronic respiratory, rheumatic, and arthritic diseases.

Heart and blood pressure patients benefit by migration to the soothing warmth of the deep South where the circulatory organs are spared the swift adjustments demanded by Northern winter storms. In addition, the summery warmth of Southern Florida or the Gulf states gradually lowers general combustion rates, resulting in less of a load on the heart and blood vessels. It's a good idea, however, for the patient to make his move Southward in easy stages, and, any trips back home should be made during the summer months to avoid dangers of too early a return to the cold and stormy North.

Recurring respiratory troubles such as chronic sinusitis, bronchitis, and bronchiectasis are often remarkably relieved by a change of scenery. The Southwest with its relative freedom from winter storms is nearly ideal for these patients for whom the endless procession of cold fronts and sudden storms in the Northern winter may be devastating. The steady, even weather that usually prevails at moderate elevations close to the Mexican border west of El Paso offers real hope of relief from racking coughs and colds that are otherwise little affected by vaccines, vitamins, or drugs.

This same non-stormy but mildly stimulating climate can also be beneficial to tuberculosis patients, provided, of course, that all other facilities for adequate care are also available. While climate alone is no cure for TB, a proper atmospheric environment can greatly reduce the danger of acute attacks and prevent

progress of the disease. Then rest, nutrition, drugs, and collapse therapy can complete the patient's recovery.

Rheumatic diseases are very much like respiratory infections in the way their incidence is related to storminess and weather changes, but the danger is even greater for patients with rheumatic infections. Chilling and changes in barometric pressure are especially hazardous for children who have had rheumatic fever, as further flareups may result in damage to the valves of the heart and permanent cardiac disability. Although the advent of long-acting forms of penicillin has brought such children a greater degree of protection from the winter sore throats that are often the prelude to additional attacks of rheumatic fever, many doctors still feel quite strongly that migration to a non-stormy climate is the only safe way to cope with this condition. Here, too, Southern Arizona and New Mexico is the region of choice because of the dry, steady warmth and the freedom from atmospheric turbulence.

Evidence is piling up that many more diseases are linked to the weather in one way or another. Changes in temperature, relative humidity, and barometric pressure have all been blamed for touching off acute attacks in such varied conditions as appendicitis, gall bladder disease, peptic ulcer, hay fever, asthma, glaucoma and other eye diseases, migraine headaches, orthopedic diseases, and mental illness. Medical climatologists claim that all of these conditions as well as diabetes, hyperthyroidism, and even most forms of cancer are amenable to climate therapy.

These authorities do not say that weather is the cause of these illnesses or that mere migration can cure them. However, since all are aggravated by the wrong kind of weather, it is reasonable to assume that they would respond favorably to weather free of harmful elements.

Unfortunately, although vast numbers of people suffer from diseases that respond to climate therapy, few are in a position to take advantage of its benefits. Major migrations involve economic difficulties too great for most of us who can't even afford a couple of winter weeks in Florida. Yet climate therapy may often make the difference between a useful, active life and one of painful invalidism. And even life itself may sometimes depend on removal to a favorable environment.

How to solve this problem has been the subject of considerable thought and discussion. Leading medical meteorologists, anxious that their specialty [*Continued on page* 82]

**The four drugs discussed in "Drug Digest," pages 56-57, do not correspond as closely to the content of this article as is our normal practice. In future months, we will occasionally depart from the practice of presenting drugs associated with an article in order that Dr. Morton J. Rodman, our consultant in pharmacology, may bring our nurse readers the latest information on certain important new drugs.**

# Drug Digest

## p-NITROSULFATHIAZOLE N.N.R. (Local Anti-infective)

**PROPRIETARY NAME:** Nisulfazole.

**PHARMACOLOGY:** This sulfonamide is used mainly for the treatment of lower bowel lesions in the medical management of nonspecific ulcerative colitis and proctitis. Unlike such other relatively insoluble and poorly absorbable sulfathiazole derivatives as phthalylsulfathiazole and succinylsulfathiazole, this drug is not administered orally, but by rectal injection for local bacteriostatic action. Its effectiveness, especially when lesions are limited to the sigmoid colon, is thought to be due to changes brought about in the bacterial flora and possibly to antilysozyme activity.

**DOSAGE:** This specialized sulfonamide is injected rectally as a 10 per cent stabilized suspension. Initially, 10 cc. may be administered after each stool, or 30 to 60 cc. may be given four times daily. Later, with improvement, the dose may be reduced to 15-30 cc. at bedtime, until healing has occurred and the patient is symptom-free.

**UNTOWARD ACTIONS:** Normally, systemic effects are few, due to poor absorption from the intestine. In the presence of large denuded areas of mucosa, however, enough may be absorbed to cause characteristic sulfonamide reactions. Discontinuing the treatment usually brings quick relief from toxic side effects.

## SULFACETAMIDE N.N.R. (Systemic Anti-infective)

**PROPRIETARY NAME:** Sulamyd.

**PHARMACOLOGY:** Sulfacetamide is effective in the treatment of severe systemic infections such as meningococcic meningitis and various respiratory tract ailments including pneumonia, otitis, pharyngitis, and tonsillitis due to invasion by beta-hemolytic streptococci, staphylococci, and pneumococci. It may also be used in urinary tract infections caused by gonococci, E. Coli, and A. aerogenes and as a prophylactic following surgery of the genito-urinary tract. The very soluble and non-irritating sodium salt is used in the treatment of various eye infections, including styes, corneal ulcers, blepharitis, and trachoma, as well as in prevention of infection after scratches and chemical burns of the cornea or the removal of a foreign body.

**DOSAGE:** In the treatment of adults, 1 Gm. of the drug is given three times a day after meals and continued for at least a week after the disappearance of all symptoms. As a prophylactic against infection following genito-urinary tract surgery, 0.5 Gm. is recommended three times a day after meals. Children receive about 0.5 Gm. for every 15 lbs., divided into three equal doses after meals.

**UNTOWARD ACTIONS:** The high solubility of sulfacetamide lessens the possibility of crystalluria common to most sulfonamides, but other minor toxic reactions such as drug fever, skin rashes, nausea, vomiting, and dizziness may occur.

## SALICYLAZOSULFAPYRIDINE N.N.R. (Systemic Anti-infective)

**PROPRIETARY NAME:** Azulfidine.

**PHARMACOLOGY:** This derivative of salicylic acid and sulfapyridine tends to be distributed to connective tissue and to be retained there in relatively high concentration. This may possibly account, in part, for its effectiveness in chronic ulcerative colitis, in which it is said to stop diarrhea and bring about healing. Treatment should be continued, even after diarrhea has ceased, and until rectoscopy reveals a satisfactory state of the mucosa.

**DOSAGE:** In cases of average severity, adults get 1 Gm. by mouth, four to six times daily. Children between five and seven years old receive 0.25-0.5 Gm., and older children between 0.5-1 Gm. three to six times daily.

**UNTOWARD ACTIONS:** The drug is converted in the body to sulfapyridine and aminosalicylic acid. Although the former proved to bu a comparatively toxic sulfonamide in clinical use, its systemic absorption here is rather low, and side effects are few. However, careful observation of the patient is suggested for such signs of toxicity as nausea, drug fever, rash, and fall in white blood cell count. Nausea of increasing severity should signify the need to reduce dosage or to discontinue the drug temporarily.

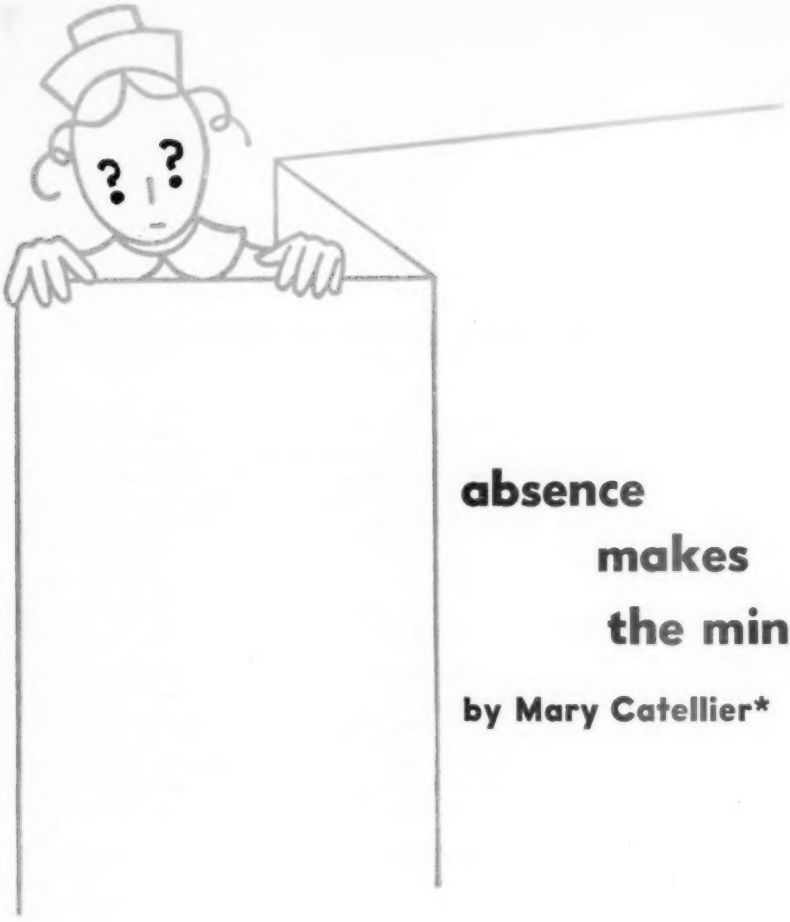
## SULFISOXAZOLE N.N.R. (Systemic Anti-infective)

**PROPRIETARY NAME:** Gantrisin.

**PHARMACOLOGY:** Due to its comparatively high solubility in urine and its antibacterial effectiveness against B. Proteus, Sulfisoxazole is especially useful in urinary tract infections. It is also used in the treatment of systemic infections due to hemolytic streptococci, staphylococci, pneumococci, and meningococci. If oral administration alone is insufficient to maintain adequate blood levels in such cases, solutions of the water soluble diethanolamine salt may be injected parenterally. The same salt, in the form of an ophthalmic ointment or solution, may be instilled into the conjunctival sac for the local treatment of superficial eye infections.

**DOSAGE:** Orally, 4 to 6 Gm. is given initially, followed by doses of 1 to 2 Gm. every four hours, until temperature has been normal or urine cultures sterile from 3 to 7 days. Parenterally, 4 Gm. of the diethanolamine salt is repeated every 8 to 12 hours, if necessary.

**UNTOWARD ACTIONS:** The usual renal complications of sulfonamide therapy are rare with this drug, due to its solubility in both acid and alkaline urine, but other reactions such as nausea, vomiting, rash, and fever may occur, requiring reduction of dosage or discontinuance of the drug.



# absence makes the mind...

**by Mary Catellier***

■ I HADN'T PRACTICED nursing in a professional capacity for several years when an R.N. friend approached me and said, "Will you relieve me for two weeks in my Doctor's office so I can take a vacation?"

The Doctor, I remembered from my training days, was a surgeon, very exacting, very "cocky." He had once thrown the wrong suture at a certain student nurse.

"Oh heavens!" I said. "It's been so LONG! I would be all thumbs and big toes. All I have done along the nursing line all these years is worm Fido and help Nellie have kittens. Oh, no, I COULDN'T!" But I was like a war horse smelling gunpowder.

And one bright July morning, there I was.

"That uniform," said Doctor, looking as if all he smelled was not attar of roses. "Can't you do something

*Housewife Catellier found her return to active nursing via a brief joust with office nursing both a stimulating and an unforgettable event.

about the way it fits your waist?"

"It's borrowed," I said, losing a large measure of self-confidence. (A loss I was in no condition to suffer.)

"Oh, well . . . " Doctor sighed. "Bring on the patients." He eyed me doubtfully. "We better get an early start."

I swished out to the crowded waiting room.

"You should remember me—I've been here before," snapped a buxom matron, first in line.

Muttering, "Well, *I* haven't!" I went into my office to pull card. Canton? Or Kanton? Do I look in the "C" drawer or under the "K's"?

Doctor stuck his head through the door and met my eyes—two big question marks. Wordlessly, he took in the situation. Silently, he inspected the waiting room. Came over. Yanked "Canton, Mrs. Irma" out from under my nose.

"Put her on the cot," Doctor said, demurely shutting himself up in his office off the treatment room.

In the brief glimpse I had had of the Patient's card, it had said something about "varicose veins." With Patient on cot, I discovered several incisions on her legs and thighs, two of which were almost in the groin. The question was: To remove or not to remove panties? Removed panties. Got Patient back on cot. Stood there, with sheet in hands, wondering how on earth you draped for such an examination. Finally used Patient's dress for drape above, then tossed sheet carelessly across ankles and feet. Debated whether lighting was ample. Or should I turn on the portable spotlight?

It was very quiet in there.

Suddenly, Doctor appeared, looking what's-going-on-in-here-ish. Both reached for spotlight at same time. I got it! Doctor began to pull off leg dressings. Then an extremely pained expression came over his face. I decided he was waiting for me to provide a place for soiled dressings. Step-on can was yards away. Did they use newspapers? All I could see was box of tissues. Hastily, I flipped one and spread it on drape sheet across Patient's ankles.

Doctor slapped down sizeable dressing and started to deposit another. Patient moved legs. Tissue, dressing, and drape became confused. I did, too. Doctor turned purple.

I (desperate) scurried over for step-on can. Lugged it back. Threw in dressings. Unwound sheet from Patient's leg with one hand while responding to "alcohol sponge, Nurse!" with the other.

A haze mercifully settled over me. During haze, fresh dressings were somehow completed. Then, while "Canton, Mrs. Irma" went in bathroom to don panties, Doctor crisply informed me that Patient had not needed to remove said panties in the first place. I nodded intelligently. Escaped to my own office so as to be sitting efficiently at desk when Patient emerged to pay fee.

Patient emerged. Behind her stood Doctor twiddling five fingers at me, which I later learned meant, "Charge $5." Thinking all was forgiven and Doctor was turning playful, I waggled five fingers back at him and

charged Patient $3 for that visit.

Second Patient (elderly matron) was brought in without mishap. I felt I was "getting" it.

"External hemorrhoid," Doctor explained to me: "Knee-chest position." I fumbled back in my memory.

"Patient on knees, face-down. On the cot," said Doctor, clicking his heels into his office and again closing the door.

I took one startled look at Patient in said position. Decided draping problem in this office was a pretty hopeless one. Tossed sheet across legs and feet. Remembered to turn spotlight on operative field. Pulled over step-on can. Tried to think of something else to do to show efficiency. Vacuum. Called Doctor.

"Scalpel," he said.

I gazed at table holding assortment of supplies.

Doctor jerked scalpel out of jar of alcohol.

I grabbed up several gauze squares. Almost fainted on discovering that

this was the right thing to do. Doctor worked silently, I swabbing here-and-there, now-and-then. Hemorrhoidal clot was coaxed out through small incision.

"Apply pressure, Nurse."

"Yes, Doctor." I dabbed gently.

"Well, APPLY it!"

Patient sagged forward on face.

"Not so much! NOT SO MUCH!"

I was already worrying how you put a dressing THERE! Found out you used piece of gauze and two strips of adhesive.

"Short NOT long, Nurse!"

"Straighten her out, Nurse."

To me this meant,"Upright the

"Zeke & Dessie"

poor soul and let her go. She has suffered enough." This was *not* what Doctor had in mind. An abdominal exam was to follow. "PUT PATIENT FLAT ON HER BACK!" I stifled strong urge to put Someone Else flat on Someone Else's back.

The patient left and others came. The battle raged on. A gauze sponge (held by me) got itself sutured to a chin during excision of large wart. It became known that although I could type quite capably, Doctor's typewriter could NOT spell forgotten medical terms. Finally, the day ended.

Doctor sank down at his telephone to return calls. I trudged into bathroom to "do" instruments and gloves. Feeling a little low, I tried to bolster my courage by singing a harmless tune.

"WHAT?" Doctor shouted from his office.

I dropped a hypo syringe. It shattered noisily.

Doctor appeared in doorway. "Good Lord! How the dickens did you do that?"

"Good Lord, I threw it on the floor and jumped on it!"

Doctor almost grinned—but caught himself in time. "Go home," he said. "You can clean up in the morning while I'm in surgery."

The two weeks went haltingly and painfully by. But they went. At the end of it, I said to myself, "Thank the Lord I lived through THAT. Never again!"

A month later I found myself relieving an office nurse across the street. Doctor had recommended me! Me!

## Candid Comments

[*Continued from page* 43]

keeping more of our people well. "Hospital figures too often seem to be flavored with a complacent satisfaction that so many people are being ill and that beds are kept so full," said Prof. H. W. C. Vines of Charing Cross Medical School to the Eighth International Hospital Congress in London, "yet surely the proper aim of medical care should be to eliminate the hospital as we know it today."

We hear a great deal more about preparing nurses for the future demands than we do about in-service programs, refresher courses that really refresh, and similar efforts to help today's nurses broaden and deepen their present usefulness. With new medicines, new treatments, new ideas of care piling up at a stupendous rate, it is plain folly to continue on the present hit-or-miss methods of keeping abreast. I almost wept when a group of fine private duty nurses told me their only way of keeping up with the new medicines was the leaflets given them by drug salesmen. And a grand old veteran, returned to general duty to help out, did weep in telling how narrowly her patient escaped death: "There was no one to answer my questions, no one to show me. Everybody brushed me off."

In-service education programs are as necessary in today's hospital as the front door. It is rather wonderful to see the growing awareness of this reflected in the increasing number of articles on the subject in our nursing publications. Anyone who *wants* ideas can find them in these articles. An unusual approach to such a program appears in Phyllis Caswell's "Developing an In-Service Education Program," in the March, 1954 issue of *Nursing Outlook*.

Happily there is also reflected in increasing degree, in nursing and hospital publications, a greater interest in staff conferences—the kind that produce results not only in better patient care but improved staff morale. It is my conviction that low morale and the exodus from general duty are caused as much, if not more, from loss of job satisfaction and abhorrence of poor patient care, as from low pay. Our literature, as well as that of business and industry, is showing an increasing respect for the values of workers' ideas. Management is learning that workers' inclusion in planning pays off generously in efficiency, economy, and the development of mutual good will. It seems incredible to me that, with some notable exceptions, there is so much lag in our field in this growing movement.

There are many signs, however, to indicate that the important matter of human relations in hospitals is on the verge of a broader and more potent development than we have ever known before. And this is absolutely essential to sound preparation for tomorrow as well as getting the work done today. I do not belive that employers of nurses can justifiably cry "shortages" if they haven't brought their personnel practices into line

with today's realities; if they are not concentrating on developing good supervision, the very backbone of good work everywhere, or if they fail to institute productive staff conferences, in-service education programs, and similar measures that bring out and develop the nurses' highest ideals, loyalties, standards, and abilities.

The functions studies and other administrative research projects now going on in many instances, and the experiments in practice going on in others, are all grist for the mill. There are a lot of fine, earnest people working patiently and conscientiously to find the answers. In physical lay-outs we do see more adjustments and planning for effecting economies in travel. But I've often wondered why more mechanical aids weren't introduced to reduce the expenditure of nursing service. Fifteen years ago, or thereabouts, I posed as a patient in Atlanta, Georgia's Piedmont Hospital, in a far-off room to test out the two-way voice communicating system to speak with the nurse at the nurses' station. At about the same period I repeated the test at the hospital of Michigan State College in Lansing, only this time the far-off desk nurse and I were exchanging breathing sounds. The saving in nurses' energy and time was marked, and the comfort to the patient was even more marked. "The two-way voice communication system has enabled us to operate with fewer nurses," wrote A. A. Lepinot, assistant administrator, St. Luke's Hospital, Cleveland, in *Modern Hospital* in 1952. Yet in these 15 years I have not seen many similar systems.

Sound ways of meeting nurse shortages are described in Lucy Germain's "How Nurses Helped with the Harper Hospital Study,"* and Jane Barton's "In Solving the Nursing Shortage It's Intelligence that Counts."** Who wants to learn can do so from these and other excellent articles. Tomorrow promises to be an interesting, challenging, ever-changing, and very busy time. We can approach it best, not primarily by counting noses, but by intelligently unifying and utilizing the forces we have today.

*"How Nurses Helped with the Harper Hospital Study," Lucy Germain, R.N., *The American Journal of Nursing*, October, 1953.

**"Solving the Nursing Shortage," Jane Barton, *Modern Hospital*, May, 1953.

## Editorial

[*Continued from page* 33]

non-member for years pay up all the back dues before reinstatement. Perhaps the greatest disadvantage was that large alumnae groups could and often did control district elections. The vote of the ANA House of Delegates at Buffalo in 1944 to drop the alumnae as an organic tie caused much distress and resentment, yet state after state has gradually stepped in line.

The adoption of the new structure superimposes on the old a whole new pattern based on occupational specialties. While the state and district organizations remain as integral units of the national, the lines of communication between them have changed. Now the sectional ties lead directly from the national into the district. On the surface, the organizational structure appears the same, but those working within this framework know differently. In the past, all policies, programs, and communications were channeled from national through state and district boards of directors. Now the lines of communication go directly from national sections to state and district sections, bypassing state and district boards.

In commenting on this new development, those who object point out that the elected representatives of the entire membership plus elected section chairmen sit on the boards of directors to consider *all* problems and to make decisions in the interests of *all* nurses. The complaint is that the current procedure of too many sections is simply to go through the formality of reporting section policy and activities to the board of directors *after* the policy or activity has been put into effect or accomplished. How much autonomy is too much?

The real danger of this organizational autonomy is to heighten the walls between nursing groups. These walls were already high, and at a time when we need less segmentation and isolationism, we appear to be getting more and more. As specialties grow up, intensities of interest increase. As each section becomes more deeply preoccupied with its own growing problems, it will be concerned less and less about the problems of other sections. And this means it will know less and less of how these groups function in the whole nursing scheme. Conference groups for discussion and exchange of professional knowledge are needed and are desirable, but conference groups need not erect structural barriers around them.

Reorganization was originally urged to streamline. There were too many committees, too much duplication. A look at the present set-up, with its multiple ANA section machinery and its overlapping of committee work in ANA and NLN—especially on the local level, makes one wonder.

Another main purpose was to create unity. True unity cannot be provided by *form* of organization. It comes only from mutual interests intent on the same goal. If sections become so engrossed in their own affairs what are the chances for the

districts to continue their development, and what are the chances for a team approach to the main problems of total nursing?

Reorganization was also advocated in the name of economy, for the members as well as for the associations. But dues-paying members have found to their dissatisfaction that it costs more to support the reorganized ANA and NLN with their multiple units than it did before.

There is definite concern among those interested in organization as to how long the district can remain a vital force as contacts with members dwindle to merely correspondence by mail and sporadic, poorly attended meetings. What is to be the function of the districts in the future? Is the main function to be a collection agency for ANA membership dues?

If our professional associations—all of them—do show signs of structural stress during the settling process, now is the time to make the minor repairs before the weaknesses become chronic. Let's take a long, hard look at our organizational machinery. Can we have both unity and separateness, economy and spiraling expenditures, representative associations without members? More organizational machinery means more paid employes; more activities mean greater budgets, and greater budgets mean the necessity of more support in the form of increased dues or more members, or both. And as one correspondent puts it, "We are now in a phase of too much of everything, except service."

—ALICE R. CLARKE, R.N., EDITOR

## Isotopes

[*Continued from page* 39]

Their chief value would appear to be that they constitute a means of detecting those who through carelessness expose themselves excessively. Such persons can be watched for a few days and evidences of poor technique can be pointed out. Film badges are also worn for medicolegal purposes to record radiation exposure.

Patients who are to receive radioactive substances are frequently taken to a special laboratory where the radioactive isotope is administered. Trained personnel are present and, if material is spilled or if the patient should vomit, there is no question of contamination except in that one area.

When phosphorus 32 is given in doses up to one millicurie, no precautions are necessary in handling the patient. In doses above one millicurie no precautions are necessary if the patient has bathroom privileges. Since phosphorus emits only beta particles, the patient himself is not a source of danger because of the slight penetrating power of these particles. Bedpans and urinals of bed patients may be handled with gloves until they have been thoroughly washed with soap and water. Any vomiting prior to absorption of an oral therapeutic dose of $P^{32}$ or $I^{131}$ is a problem for the radiation safety officer. Vomiting the day after, possibly due to radiation sickness, is not likely to yield dangerous material.

When radioactive iodine is given in tracer doses only, there is no need for special care. However, when the drug is given in therapeutic doses for hyperthyroidism, enough radioactive material may be excreted in the urine, or in vomitus to warrant precautionary measures. Rubber gloves may be worn when handling bedpans or urinals. Urine is usually saved for a few days and sent to the laboratory for assay.

In the event that large therapeutic doses of iodine 131 are given for the destruction of the thyroid or for treatment of thyroid cancer, and profuse sweating occurs it may become necessary to resort to rubber gloves when handling the patient. Usually, baths are omitted during the first 48 hours. Hands are always washed

ever dream

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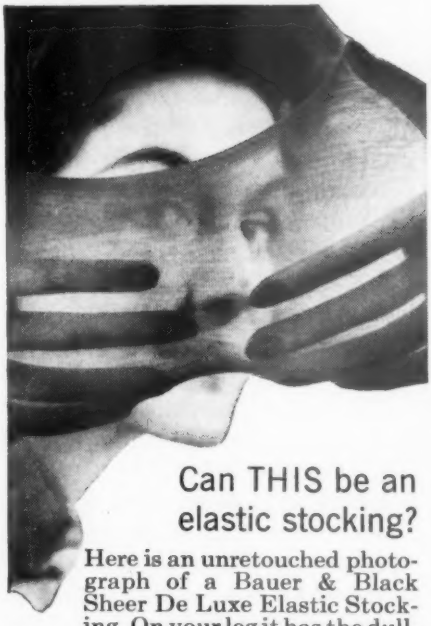

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thoroughly with soap and running water after giving the patient personal care. Rubber gloves are used to handle bedpans and urinals. Urine is saved for at least a week in bottles stored in an isolated or shielded area. In the case of profuse sweating or contamination with urine, linens are handled with rubber gloves. The radiation department is notified if urine is spilled on the bedclothes. Such linen can be stored temporarily in a metal hamper with a laundry bag inside. A garbage can with a foot pedal and a waterproofed paper lining may be utilized for other potentially contaminated items. Contaminated material is taken to the physics laboratory where it is stored until it becomes relatively inactive.

Again, it is the responsibility of the radiation safety officer to determine how long this special treatment is needed. He will also determine whether personnel and patients in the adjacent beds run any risk because of emanations from the radioactive patient and will give instructions concerning precautions to be taken. In some cases, though personnel may not be in any particular danger since their attendance upon the patient is intermittent, it may be necessary to move patients in adjacent beds to a more remote spot for these patients are *constantly* within an area of radiation.

Patients receiving very large doses of either radioiodine or radioactive gold are usually treated in private rooms because of the problem of radiation. Rooms lined with lead have even been utilized in some instances where radioactive gold has

been given, although this is not ordinarily necessary. Gloves, gown, and a rubber apron may all be worn by nurses who assist the doctor in the administration of gold 198, and the ancillary equipment such as drapes, furniture, etc., is checked for contamination after completion of the procedure and disposed of according to the direction of the radiation safety officer.

Patients are not usually bathed for 48 hours following administration of the gold. Gloves are worn while caring for the patient and are discarded in a special container in the patient's room. Bedclothes and other linens are placed in a special hamper which is also kept in the patient's room; discarded paracentesis dressings are *never* placed in the linen hamper but in a special container provided for them. (The fluid leaking from the paracentesis wound is also hazardous.) Usually it is not necessary to carry out these precautions any more than 48 hours from the time of administration of the gold.

The treatment of patients with radioactive isotopes is not hazardous to hospital personnel if common-sense safety measures are observed. Experimenters at Oak Ridge, Tennessee, found that over a three-month period in a ward, the average patient-load of which was seventeen people, radiation received by personnel did not exceed that received by the workers in a busy x-ray department. *Respect for* rather than *fear of* these materials would seem to be the key to successful participation in such programs.

## Authoritarianism

[*Continued from page* 47]

endlessly differ over the issue of the nurse as a servant of the institution versus the hospital as the clinic for the education of the nurse. While this dissension takes place neither the nurse nor the patient is being served. To help straighten out this tangled mass of human relations each nurse can look for the meaning of her place in today's nursing.

Today's nursing demands not only modification of the individual so that she may work cooperatively with others, but it also demands modification of organizations and institutions by individuals. It is not a time for obstinate decisions by a few. All of us have been wrong part of the time and right part of the time. The imperative challenge of today is that enough of us belonging to this profession, so closely linked with human progress, be right *now* in promoting socially sensitive improvements in nursing service and nursing education on democratic principles.

What is expected of the thoughtful individual nurse in this crisis?

First, she will become acutely conscious of actual problems where she is.

Second, if she rebels against the dominant traditions in nursing and realizes that what progress has been made has not been due to fidelity to tradition, she will be willing to sacrifice something for the sake of improvement, to better nursing conditions, and greater nursing happiness.

Third, she will not be afraid of her responsibility as a member of a nursing staff, a free faculty, or organization. She will not look for canned opinions and ready-made philosophies, and she may even stick her neck out to prove the validity of her own standards and principles. She will work in professional organizations. She may go so far as to have a sudden shift of opinion with no fear of being self-contradictory.

Fourth, she will realize that although an absolute essential is independence of judgment, decisions are reached by discussion and the democratic process. Discussion becomes a mockery, she will know, if judgments are imposed from above, and above may mean the nurse above the auxiliary worker as often as the director above the nurse, the doctor or administrator above the director.

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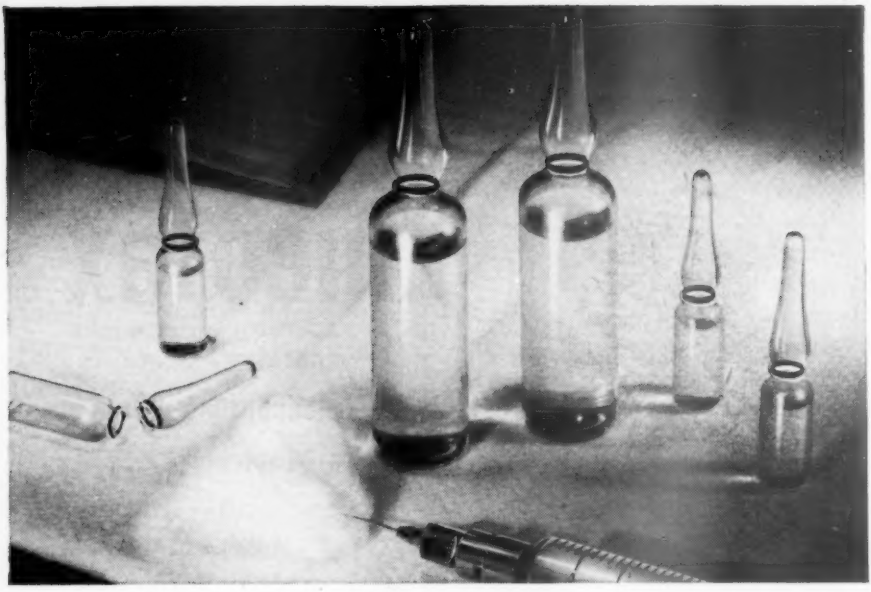
## Cancer Nursing

[*Continued from page* 40]

cer nursing care are readily available for nurses in general hospitals, and institutes on the subject are held in various parts of the country. For, it is as true in 1954 as it was in 1870, when the surgeons at the Royal Cancer Hospital in London, the world's first permanently established cancer hospital, attributed their successful achievements in large measure to "the admirable nursing we possess," that nursing is an essential feature of the care of the cancer patient.

## High School Nurses

The shortage of nurses may be eased with the inauguration of a four-year nurse training program in the New York City high schools this fall. Developed in cooperation with the State Education Department and the New York State Nurse License Bureau, the plan provides for a paid work-study period during the last of the four years. Only students with suitable aptitude and interest, however, will be allowed to take part in the final year's twenty-four weeks of clinical study and twenty-four weeks of classroom instruction. The new program is expected to graduate 200 qualified practical nurses each year. On graduation, providing the student is eighteen, she may immediately take the state examination, and having passed it, begin work. The first high school students to qualify under the new course will be graduated in 1956.



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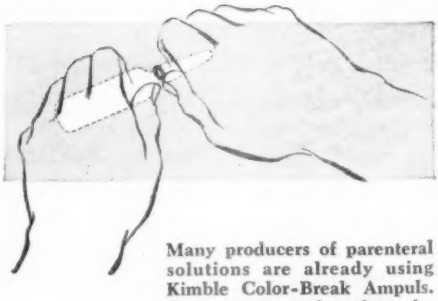

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[*Continued from page* 49]

the maximum will go up to $108.50 –provided he has worked for at least six quarter-years after next January 1 at a salary of at least $4,200. The new bill also includes a Senate provision whereby retired persons between the ages of sixty-five and seventy-two can earn as much as $1,200 a year without sacrificing their social security benefits . . . The new federal tax law that was passed contains the following revisions among others intended to bring tax relief to individuals who already are carrying a heavy financial burden: widows, widowers, and divorced or legally separated parents who work may deduct up to $600 annually for child care expenses, provided the child is under twelve, or, is mentally or physically incapable of caring for himself. This also applies to working couples whose combined income does not exceed $4,500. The definition of dependents has been broadened to include foster children, and in fact, a taxpayer may now claim a $600 exemption for any dependent member of his household, irrespective of relationship. Also, a parent may count his minor child a dependent even if the child earns more than $600 a year. A widow (or widower) with a dependent child is now entitled to full income-splitting benefits for two years following the death of her husband. After that she gets only one-half the benefit of income-splitting–the same arrangement that is available (under present law) to single persons who are the head of a household. Head of a household status has been extended to children who maintain separate homes for dependent parents. And, under the new law, persons with retirement pensions receive limited tax exemption by means of a tax credit–amounting to 20 per cent of the first $1,200 of pension (or $240)–that may be subtracted from the amount of tax owed. This applies to persons over sixty-five generally and to those under sixty-five if they retire under a government retirement system. A husband and wife can each get this credit if each qualify. Generally, provisions of the tax measure are retroactive to January 1 of this year. The filing date for personal income tax returns has been changed from March 15 to April 15 . . . The synthetic blood plasma expander, PVP - Macrose (Schenley Laboratories), has been granted new-drug clearance by the Food and Drug Administration . . . National Nurse Week, October 11-16, will afford the profession and other interested groups an opportunity to remind the public that the quality of nursing is in large measure dependent upon public interest and support.

▶ TWO NURSING GROUPS in Connecticut, the State Nurses Association and the State League for Nursing, have cooperated with the Connecticut TV Committee for Health Education in sponsoring a thirteen-week series of weekly television programs over WNHC-TV, New Haven. The committee, which

is composed of a large number of health and disease prevention associations and the Connecticut State Health Department, was formed about a year ago to provide the state's television and radio stations with authentic health information. The TV series represents the committee's first attempt to teach health measures through this medium.

▶ REVISIONS in group insurance practice may result from a unique experiment in preventive medicine recently conducted at Stockton, Calif., where 900 members of the International Longshoremen's and Warehousemen's Union-Pacific Maritime Association were given health tests in an effort to detect early signs of chronic illness. The experiment was sponsored jointly by the Association, the Continental Casualty Company, Chicago, and the San Joaquin County Medical Society.

▶ A CLINICAL SPECIALTY provides the nucleus for the Intersectional Conference Group for Operating Room Nurses that is currently being established within the Maryland State Nurses Association. Although in the present ANA structure, section membership is based upon occupational groupings and not on clinical specialties, the establishment of this intersectional conference group is consistent with a resolution adopted by the house of delegates at the 1954 ANA Convention. At this time, state nurses associations were urged to determine the need and desire for intersectional conferences for clinical specialty groups, and encourage their establishment.

▶ A MEDICAL TECHNOLOGY four-year program designed to prepare students for positions in hospitals, clinics, research laboratories, and industry, as well as physicians' assistants has been established at Elmira College (N.Y.), in conjunction with the Arnot-Ogden Memorial Hospital. Following three years of basic training at the college, the students will take twelve months of instruction at the hospital, receiving a B.S. degree at the successful conclusion of the course. Then, after taking and passing an examination offered by the Registry of Medical Technologists, students receive the Registry's certificates in medical technology.

## Climate

[*Continued from page* 55]

benefit larger numbers of people, want the government to provide accommodations in the Southwest and other areas for those whose health and well being require a permanent change of residence. They argue that financing the migration and resettlement of thousands of weather "cripples" would actually increase the national wealth by restoring the productivity of many workers now totally incapacitated by disease. In any case, these advocates of federal assistance claim that setting up camps and colonies for those who could not otherwise afford climate therapy would be a public health service not different essentially from many others which we now take for granted.

Although plans for national climate reserves don't seem to be making much headway at present, the political power of the ever-increasing number of the aged in our population may make this dream a reality some day. Elderly people benefit most by permanent moves to regions of warm, gentle, steady weather, and many will want to live out their lives after retirement in a soothing, Southern climate.

But you don't have to be old or ill to make the most of what science now knows about weather biology. Planning your personal and professional activities with an eye on the weather can bring you and your patients dividends in added comfort and health.

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## WITH A SMART
# New Slant!

A fashion pace-maker . . . . in our exclusive, Sanforized Ripplette fabric. Has diagonal tucking on bodice, wing collar and cuffs of the Dolman ¾ sleeves . . . with wonderful new *Speed Studs* on the waist front and cuffs! Pleated skirt has side-gripper opening. Sizes 10 to 18, 9 to 15. (In short sleeves, Style 0808) Style 808 shown, about **$8.00** At leading stores everywhere; write us for free Style Catalog and name of nearest dealer.

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New *Speed-Stud,** exclusive Bob Evans improvement . . . it glides into buttonholes with speed, ease, and assurance —ends fumbling and fussing with old-style toggle buttons!

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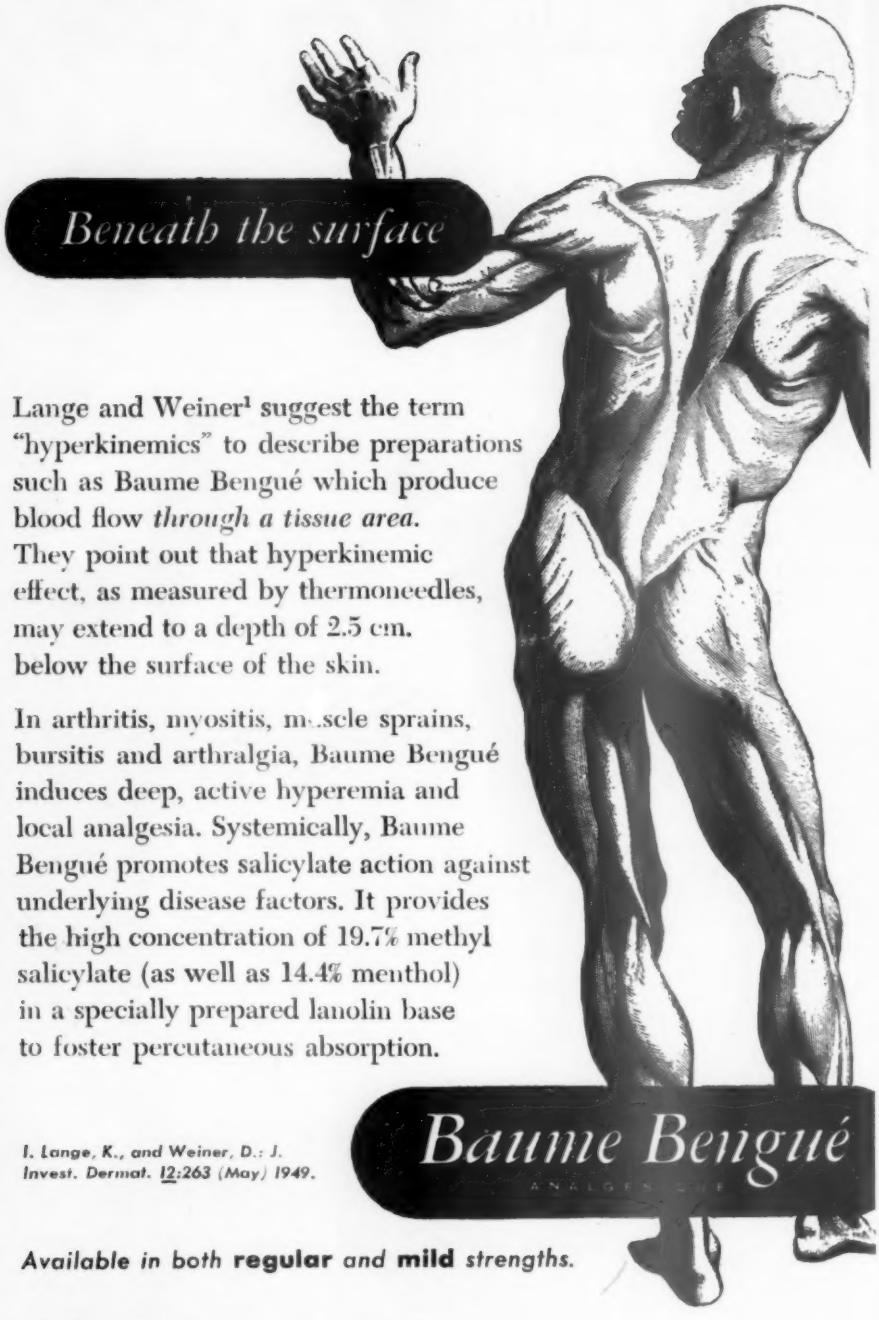

## *Beneath the surface*

Lange and Weiner[1] suggest the term "hyperkinemics" to describe preparations such as Baume Bengué which produce blood flow *through a tissue area.* They point out that hyperkinemic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin.

In arthritis, myositis, muscle sprains, bursitis and arthralgia, Baume Bengué induces deep, active hyperemia and local analgesia. Systemically, Baume Bengué promotes salicylate action against underlying disease factors. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

*1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.*

## *Baume Bengué*

ANALGESIC

***Available in both regular and mild strengths.***

*Thos. Leeming & Co. Inc.* 155 East 44th Street, New York 17, N.Y.

# Positions Available

**ADMINISTRATORS:** (a) Gen'l hosp., 90 beds; coll. town, near univ. city, MW. (b) New gen'l hosp., 50 beds; resort town, on Gulf of Mex. (c) Small gen'l hosp; resort area, Colo. RN10-1. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**ANESTHETIST:** Starting salary $350 mo. Methodist Hospital, 6th St. and 7th Ave., Brooklyn, N.Y. SO8-6000, Ext. 142.

**ANESTHETISTS:** (a) New gen'l hosp. affil. 9-man group; winter resort town, So. (b) Chief and 2 staff; 350-bed hosp. increasing services; med. anes. in charge; univ. med. center, MW; oppor. continuing studies; min. $500 (Chief), $450 (staff). (c) Fairly lge gen'l hosp; wonderful year-round climate; Pacific Islands; min., $4700, quarters. (d) Ass'n with clinic operating own hosp; resort town, So. Calif. (e) Anes-supt; small hosp; coll. town, Wis; $500, mtce. (f) Gen'l hosp., 300 beds; univ. city near several resort towns, So; $500 plus %, aver. $700-$800. RN10-2. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**ANESTHETISTS:** A.A.N.A. member. 250 bed general hospital, salary open, automatic increases, laundry provided, 40 hr. week, no obstetrics, liberal vacation and personnel policies, Social Security. Sutter Hospital, Sacramento, Calif.

**CLINICAL INSTRUCTOR:** In Obstetrics. 332 bed hospital located in an attractive residential section. Student body of 160. Degree in Nursing Education and some teaching experience preferred. Salary range for 40 hr. week, $320-$430. Beginning salary commensurate with experience and preparation. Liberal personnel policies. Living accommodations available. Apply to Director of Nursing, The Toledo Hospital, Toledo 6, Ohio.

**DIRECTOR OF NURSING SERVICE:** For 310 bed modern hospital of ideas. Must be qualified by preparation and experience. Apply Personnel Manager, The University of Texas, M.D. Anderson Hospital, Houston, Tex.

**DIRECTORS OF NURSING:** (a) Gen'l hosp., 600 beds, affil. med. school; oppor. selecting own assistants; $10,000. (b) Collegiate school; 3-yr diploma, 4-yr degree; med. center, So. (c) Ass't dir; oppor. succeeding director within few years; one of leading hosps; Calif. (d) Gen'l hosp., 200 beds; excel. staff; foreign assignment. (e) New hosp. & school; Jordan. (f) Nursing service; teaching hosp., 400 beds, E. (g) Vol. gen'l hosp., 300 beds; univ. affil. univ. & resort city, So. (h) Small gen'l hosp; fashionable suburb; MW. (i) Ass't dir. in charge of nursing service; 350-bed gen'l hosp; interesting city, outside US; mild, pleasant climate. RN10-3. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**FACULTY POSTS:** (a) Dir., vocational nursing prog; coll. affil; attrac. location, Pac. Coast; $500-$750. (b) Dir., 4-yr degree prog in nursing recently estab'd by state univ. (c) Educ. Dir., ped. instructors, Brazil, India; psy. instructor, Brazil; nursing arts, Jordan. (d) Ed. dir; clin. coordinator, clin. instructors, med., sur., ped; new hosp, 350 beds; So. (e) Ed. dir; fairly lge hosp; New Eng; $6000. (f) Dir. nursing ed., liberal arts coll; spec. courses, public health, indus. nursing; Canada. (g) Ed. dir., instructors in ped., psy., ob; students mainly Orientals; lge gen'l hosp; outside US. (h) Nursing arts & science instructors; collegiate school; coll. town, MW; $4500-$5000. RN10-4. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**GENERAL DUTY NURSES:** 5 day week, 3 week vacation, 7 paid holidays, paid overtime, liberal sick leave and hospitalization benefits, attractive living quarters, modern well-equipped 210 bed hospital. Salary starts at $230 a month. Rotating shifts. Pleasant New York City suburb, 35 minutes from Grand Central Station. Contact Director of Nursing Service, White Plains Hospital, White Plains, N.Y.

**GENERAL DUTY NURSES:** For beautiful crippled children's hospital located in heart of historic west. Salary starts at $205 per mo. with complete maintenance, 15 days vacation, 15 days sick leave, 5 day work week. Climate is warm and dry. Hospital has indoor and outdoor pools available to personnel. Contact director of nurses, Carrie Tingley Hospital for Crippled Children, Truth-or-Consequences, N.M.

**GENERAL STAFF NURSES:** This is a nice place to work in preferred department of 200 bed general hospital with liberal personnel policies including 40 hr. wk., choice of two schedules, retirement plan, paid hospitalization insurance premium, cumulative 30 day sick leave, pro-rated and progressive vacation, 6 holidays annually, meals at cost, rooms for $20 monthly in residence beautifully located directly on Detroit River and 30 minutes from Detroit. Beginning salary, evenings $304.47-$313.13; nights, $299.47-$308.13; days, $289.47-$298.13. For details write Director of Nursing, Wyandotte General Hospital, Wyandotte, Mich.

**GENERAL STAFF NURSES:** 250 bed general hospital and 72 bed maternity hospital.

Starting salary $280, $5 per month tenure increase for each 6 months of service to a maximum of $310. Social Security, sick leave, prepaid medical and hospital care. $10 additional for afternoon and night shift, $10 additional for delivery room, $20 additional for surgery. Up to 3 weeks vacation at end of 4 years. 7 paid holidays, 8 hr. day, 40 hr. week. Apply to Director of Nurses, Sutter Hospital, Sacramento, Calif.

**GRADUATE NURSES:** Two. If interested contact Medical Director, Florida State Hospital, Arcadia, Fla.

**GRADUATE REGISTERED NURSES:** For 398 bed general hospital with School of Nursing. Full or part-time. Excellent opportunity for study at Western Reserve University. Starting salary $240-$260 based on experience plus $1.00 per diem for evening or night duty. Operating room nurses $10 per mo. additional. Two weeks vacation, 6 holidays, 10 days sick leave. For detailed personnel policies write Director of Nursing, Mount Sinai Hospital, 1800 East 105th St., Cleveland 6, Ohio

**INDUSTRIAL, CLINIC, OFFICE, STUDENT HEALTH:** (a) Indust. nurse qual. dir. staff of 12; univ. city, MW. (b) Student health; lge univ; new dept. (c) Stewardess; transcontinental. (d) Clinic nurses; new univ. hosp., W; oppor. continuing studies. (d) Clinic, famed hotel; substantial sal., apartment; univ. city; oppor. continuing studies. (e) Office nurse by well qual. woman M.D.; E. (f) Coll. nurse; state coll; So. (g) Counselor and recreational director; lge tch'g hosp; E. RN10-5. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**MALE NURSES:** (a) Supt., priv. psy. hosp; univ. city, MW; $5200, mtce. (b) Anes; small gen'l hosp; lge city med center; $8-$9000. RN10-6. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**MEN NURSES, REGISTERED:** Several positions open in all-male hospital. Starting salary $280. 3 weeks paid vacation after 1 year. Usual holidays. Morning and afternoon shifts. Differential for afternoon, evening. Address: Director of Nursing, Alexian Brothers' Hospital, St. Louis 18, Mo.

**NEW YORK STATE JOBS FOR NURSES:** Qualified nurses with 2 years' supervisory experience earn $4350-$5460 as inspectors of welfare institutions in New York City. Career with professional status, security, pension at 55 or over, 37½ hr, 5 day week, 4 weeks' vacation plus holidays, sick leave with pay. For qualifications and other requirements, contact John J. Keppler, New York State Dept. of Social Welfare, 270 Broadway, New York 7, N.Y. BArclay 7-1616, Ext. 7301-7302.

**NURSE ANESTHETIST:** For Oral Surgeons' office. Pleasant working conditions. Regular working hrs. 5, and 5½ days alternating weeks. Good future. Box HMS-1 c/o R.N. Magazine, Rutherford, N.J.

**NURSE ANESTHETIST:** General hospital, 700 beds. Starting salary $4300 per annum, maximum $4800 per annum, $100 yearly increments, vacation and sick time. Full maintenance provided. Contact A. G. Chmelnik, M.D., Medical Director, The Harrison S. Martland Medical Center, 116 Fairmount Ave., Newark, N. J.

**NURSE ANESTHETIST:** 350 bed approved general hospital, 20 minutes from New York City. Salary from $285 to $345 per mo. with full maintenance. 40 hr. wk. Bonus of $7.50 for call duty. Average one night per week call. Four weeks vacation plus 7 paid holidays. Department headed by anesthesiologist. $25 extra per mo. for living out. Write Box PH-1 c/o R.N. Magazine, Rutherford, N.J.

**NURSE ANESTHETIST:** Permanent opening at high salary beginning October 15, 1954. Write Box FC-1 c/o R.N. Magazine, Rutherford, N.J.

**NURSE ANESTHETIST:** To also act as Supervisor of floor on one shift at this small 25 bed hospital, average 20 operations per mo. Another anesthetist to share anesthesia given. Salary $382.50. Tunica is 34 miles south of Memphis, Tenn. All applications treated in strict confidence. Correspondence will be promptly answered. Send complete history in first letter to the Administrator, Tunica County Hospital, Tunica, Miss.

**NURSE ANESTHETIST:** Approved hospital near Detroit. $461 per mo. Overtime after 40 hrs. per week. Living quarters available. Wyandotte General Hospital, Wyandotte, Mich.

**NURSE ANESTHETISTS:** Two. To increase our staff of nurse anesthetists. The hospital is 116 beds, new, modern and well equipped. Salary is based on a 5 day week and case basis is used for overtime. Address: Mrs. Carolyn Heisler, Administrator, North Shore Hospital, 9200 N.W. 11th Ave., Miami, Fla.

**NURSE ANESTHETISTS:** Two. Above average salary. Medical Anesthesiologist in charge. Inquire C. K. Shire, Administrator, Montana Deaconess Hospital, Great Falls, Mont. Call at hospital expense.

**NURSE, R.N.:** Treatment, research hospital, children, rheumatic fever, lower Westchester. N.Y. $255 mo. start, $15 increment 6 mos. Call Mrs. Culver, IRvington 9-6700, 10 am-4 pm.

**NURSE-RECEPTIONIST:** Resident position for registered or practical nurse for small school 27 miles from New York City. Salary open. Box SE-1 c/o R.N. Magazine, Rutherford, N.J.

**NURSES:** Excellent employment opportunities for nurses, ages 25-48, as traveling nursing representatives. Qualifications: Bachelor's Degree in Public Health Nursing or Nursing Education plus supervisory experience. Openings available in the eastern and southeastern sections of the country. Salaries commensurate with training and experience. Direct inquiries to Mr. Norman A. Durfee, National Director for Personnel Services, National Headquarters, American Red Cross, Washington 13, D.C.

**NURSES:** Have immediate openings for registered medical, surgical and obstetrical nurses for day, evening and night duty. Minimum

starting wage $250 per mo. $15 per mo. differential for evenings and night duty. 40 hr. wk., paid vacation, 6 legal holidays, sick leave and excellent working conditions, laundry furnished. Write, wire, call or apply in person o the Personnel Dept., Research Hospital, Kansas City, Mo.

**NURSES:** General hospital, 236 beds, new building, modern equipment. 30 miles from New York City. Liberal personnel policies. Write Director of Nursing, Morristown Memorial Hospital, Morristown, N.J.

**NURSES:** General Duty, for 30 bed hospital 35 miles from New York. Excellent salary. Apply Administrator, Tuxedo Memorial Hospital, Tuxedo Park, N.Y.

**NURSES—GENERAL DUTY & SURGICAL:** For 165 bed hospital in residential suburb of Chicago. 40 hr. wk. Cash salary $230 for night duty, $225 evening duty and $215 day duty. $10 increase after 60 days and at regular intervals. $15 differential for surgical nurses. Full maintenance in addition to salary includes single room in new nurses residence plus meals and laundry. Low rental apartments for married nurses. 2 to 4 weeks vacation, 6 holidays. Sick time policy. Free life insurance. Blue Cross hospitalization. Leave of absence with full salary for post graduate study granted to qualified nurses. Write Director of Nursing, MacNeal Memorial Hospital, Berwyn, Ill.

**NURSING ARTS INSTRUCTOR:** 240 bed non-profit hospital, beautiful location, new nurses' school and home. Salary dependent upon experience, full maintenance if desired. 40 hr. wk., degree required. Apply Director of Nursing, St. Joseph's Hospital, Reading, Pa.

**NURSING ARTS INSTRUCTOR:** Nationally accredited school, 75 students. B.S. Degree and teaching experience required. 40 hr. wk. and employee benefits. Apply Dean, Knapp College of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

**OBSTETRICAL SUPERVISOR:** 225 bed general hospital, nationally accredited school, 75 students. Degree required or special preparation for teaching obstetrics. 40 hr. week and employee benefits. Apply Director of Nursing, Santa Barbara Cottage Hospital, Santa Barbara, Calif.

**OFFICE NURSE:** For general practitioner in resort area of southwest Missouri. 5 day week, beginning salary $250 per mo. with laundry furnished. Apply Box 500 c/o R.N. Magazine, Rutherford, N.J.

**OPERATING ROOM NURSE:** For 100 bed general hospital. Salary concurrent with prevailing rates. 44 hr. wk., 3 wks. vac. with pay. 8 pd. holidays, 12 days sick leave plus added benefits. Apply Director of Nurses, Augusta General Hospital, Augusta, Me.

**OPERATING ROOM NURSES:** 300 bed hospital, 40 hr. week, all cash salary. Special consideration for experience and advanced preparation. Bonus for "on call". Liberal personnel policies, including Social Security, plus a retirement plan. Apply Director of Nursing, Mercer Hospital, Trenton 8, N.J.

**OPERATING ROOM SUTURE NURSES:** For new 144 bed hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter resort areas. Air-conditioned operating suite of five fully equipped rooms. 40 hr. wk. Minimum starting salary of $270 to $370 per mo. including call. Excellent personnel policies. Opportunities for advanced professional education. Living accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

**OVERSEAS JOBS:** Booklet tells how and where to apply for overseas employment with major American firms. Write Len Rathe, Box 26244, Los Angeles 26, Calif.

**PROFESSIONAL REGISTERED NURSES:** For Staff and Supervisory capacities. 100 bed hospital in a beautiful summer resort area on Lake Huron. Staff Nurses, $275, Surgical Nurses, $297, Supervisors, $308 beginning salaries with $10 monthly differential for evening and night duty for a 40 hr. wk. Apply Director of Nursing. Alpena General Hospital, Alpena, Mich.

**PSYCHIATRIC STAFF NURSE:** For a private psychoanalytically oriented hospital, increasing staff to prepare for increase in bed capacity to 113. In-service program. 18 working days vacation, 15 working days sick leave, evening and night differential. Social Security. Beginning salary $300. Apply to Mr. Basil Cole, Personnel Director, The Menninger Foundation, Topeka, Kans.

**PUBLIC HEALTH NURSE:** Near Chicago-Milwaukee. Generalized program. Salary $3636-$3996, retirement, sick leave, insurance. Write Senior County Nurse, Court House, Kenosha, Wis.

**PUBLIC HEALTH NURSE I and II:** Salary $3840-4530 depending upon training and experience. City and school generalized service program. Career, retirement, sick and annual leave benefits. Apply Personnel Department, City Hall, Saginaw, Mich.

**PUBLIC HEALTH, SCHOOL:** (a) PH supervisor—ed dir; generalized prog; univ. city, SW; $4500-$6000. (b) Foreign assignments; degrees, exp. req; knowledge French, Spanish or Portugese desired. (c) Direct, school health prog; res. town. Chicago area; faculty salary. (d) Supervisor, staff of 18 PH nurses; county dept; E. RN10-7. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**PUBLIC HEALTH NURSING STAFF POSITIONS:** Available Napa County, Calif., located 54 miles northeast of San Francisco. Salary range $315 to $383 per mo. Full-time Health Dept., with qualified Director of Public Health, Director of Nurses, Sanitarians, Bacteriologist, and Psychiatric Social Worker. Apply to Edward R. Pickney, M.D., M.P.H., Director of Public Health, P. O. Box 749, Napa, Calif.

[Turn the page]

**PUBLIC HEALTH STAFF NURSES:** For generalized program in County Health Dept., north San Joaquin Valley, Calif. 5 day, 40 hr. week. Salary $318 to $385 at 5th year. Car furnished. Vacation, sick leave, retirement and hospital insurance in effect. Certificate in Public Health Nursing and California driver's license required. For further information write George F. O'Brien, M. D., County Health Officer, P. O. Box 1607, Modesto, Calif.

**QUALIFIED PUBLIC HEALTH NURSES:** Salary range $4205 to $4955 and Junior Public Health Nurses, $3795 to $4545. Liberal Federal Government Retirement Plan. 40 hr. 5 day week, annual and sick leave. Opportunities for study and cultural development in the Nation's Capital. Apply to Mrs. J. P. Prescott, Chief, Bureau of Public Health Nursing, Department of Public Health, 300 Indiana Ave., N.W., Washington 1, D.C.

**R.N.'s:** Under age 50. Beginning salary $310 per mo. $5.00 longevity increase every 6 mos for 3 years. Retirement plan, sick leave benefits, 11 holidays, 3 weeks vacation. 40 hr. week. New modern residence. State eligibility for California registration and submit photo to Director of Nurses, Tulare-Kings Counties Tuberculosis Hospital, Springville, Calif.

**REGISTERED, GRADUATE OR PRACTICAL NURSES:** Night or day. Deborah Sanatorium, Browns Mills, N. J.

**REGISTERED NURSE ANESTHETIST:** Tired of big city pressures? 135 bed general hospital in charming southern city of 18,000, short drive from Gulf of Mexico. Well qualified surgical staff. Salary range $380-$416 a month commensurate with experience. 4 weeks vacation with pay, sick leave, 2½ day weekend every 4th week. Apply Chief Anesthetist, John D. Archbold Memorial Hospital, Thomasville, Ga.

**REGISTERED NURSE ANESTHETISTS:** 40 hr. week, permanent positions open for surgery and obstetric departments. Liberal vacation and sick leave policies, Social Security. Overtime pay, extra pay for night duty, automatic pay increases. Living accommodations available. Apply: Chief Nurse Anesthetist, Harper Hospital, Detroit 1, Mich.

**REGISTERED NURSES:** 2488 bed VA neuropsychiatric hospital. 30 days paid vacation and 15 days paid sick leave per year. 40 hr. week. Salaries starting at $3740 or $4400 annually depending on qualifications. Yearly increases. Apply to Personnel Officer, Veterans Administration Hospital, Northport, L.I., N.Y.

**REGISTERED NURSES:** All shifts. Liberal benefits. New hospital located in beautiful Ohio Valley. At present 26 beds and being enlarged to 56 beds. Openings immediately. Contact Rozella Wilson, R.N., Director of Nurses, Adams County Hospital, West Union, Ohio

**REGISTERED NURSES:** Needed by 140 bed Physical Medicine and Rehabilitation Hospital fully accredited by Joint Commission on Accreditation of Hospitals, treating patients with neuromuscular disabilities. Salary range $245 monthly to $285. In addition to salary complete maintenance provided in air-conditioned Nurses' quarters, plus pay differential for evening and night duty. Completely air-conditioned hospital is well located in relation to San Antonio, Austin and Gulf Coast. Delightful warm and dry winters. Contact the Administrator, Gonzales Warm Springs Foundation, Gonzales, Tex.

**REGISTERED NURSES:** For general duty in beautiful modern 45 bed hospital. Good salary with full maintenance. 44 hr. wk., automatic salary increases, retirement benefits. Apply D. D. Parke, Supt., Memorial Hospital, Belle Glade, Fla.

**REGISTERED NURSES:** A few positions for General Duty and Operating Room Nurses immediately available. Hospital fully accredited. Situated in pleasant suburban location, 8 mi. from Boston. Base rate of pay 40 hrs. Time and one-half for overtime. Average work week, 44 hrs. Automatic pay adjustment semi-annually for first 2 years. Increased pay for evening and night shifts. Social Security, retirement plan, sick leave, paid vacations, paid holidays. Living-in facilities available. Ample opportunity for advancement for qualified employees. Apply to Director of Nursing (in writing), The Waltham Hospital, Waltham, Mass., or call WAltham 5-1630.

**REGISTERED NURSES:** For new 144 bed hospital located in a friendly city of 93,000 at the gateway to Michigan's summer and winter


CORICIDIN pediatric MEDILETS

resort areas. Staff and charge positions open. Salaries dependent upon educational background and experience with a minimum of $260 to $320 per mo. Monthly differential of $20 for afternoon duty and $15 for night duty. 40 hr. wk. Excellent personnel policies. Opportunities for advanced professional education. Accommodations available in the immediate vicinity. Personnel Director, St. Luke's Hospital, Saginaw, Mich.

**REGISTERED NURSES:** For supervisory and General Staff positions. Liberal personnel policies. 40 hr. wk., Social Security and Blue Cross available. $20 monthly differential for 3-11 and 11-7 shifts. Apply Director of Nurses, Niagara Falls Memorial Hospital, Niagara Falls, N. Y.

**REGISTERED PROFESSIONAL NURSES:** For supervisory, educational and general staff positions. Liberal personnel policies. 40 hr. week. Differential salary for evening, nights and operating room. Social Security. Christ Hospital, 176 Palisade Ave., Jersey City, N.J.

**REHABILITATION NURSES:** Prospective openings in a unique and challenging position requiring nurse counseling of seriously injured industrial workers through all phases of medical and rehabilitation programs. Recent graduates with B.S. Degree and some working experience desired. After preliminary training program, assignments will be made to branch offices in South, California and the Middle West. Travel with company car involved. Starting salary $3500 annually. Group Health and Insurance plans, 5 day week, paid vacations. Write W. S. Allan, Liberty Mutual Insurance Co., 175 Berkeley St., Boston, Mass., giving full resume of experience.

**STAFF NURSES:** Wide clinical experience. 40 hr. week, starting salary $280 a month. For further details please write to Dept. of Nursing, University Hospital, Ann Arbor, Mich.

**STAFF NURSES:** New 150 bed hospital near Sun Valley, Idaho. $220 per mo., 40 hr. wk., evening and night differential, annual increases. Housing available. Write Director of Nursing Service. Magic Valley Memorial Hospital, Twin Falls, Idaho

**STAFF NURSES:** For 458 bed Tuberculosis Hospital pleasantly situated about 20 miles from New York City. Beginning salary $271, increments $10 a mo. yearly to $321. $10 increase for evening or night duty. 40 hr. 5 day week with overtime for any work over 40 hrs. Liberal vacation, holidays and sick time. Full maintenance available at $52 a month. Pension Plan. Apply Supt. of Nurses, Essex County Sanatorium, Verona, N. J.

**STAFF NURSES:** For 45 bed general hospital, completely remodeled and new equipment. 44 hr. week. Starting salary $250 up. Good working conditions. Liberal personnel policy. Apply Administrator, Coon Memorial Hospital, Dalhart, Tex.

**STAFF & OPERATING ROOM NURSES:** New 104 bed general hospital. Latest equipment, ideal location banks of St. Joseph River, heart of fruitbelt, Lake Michigan shores. Living accommodations available. Jr. College in area. 2 hrs from Chicago. 40 hr. week, basic salary $234, shift bonus, good personnel policies, friendly community. Details write Nursing Director, Memorial Hospital, St. Joseph, Mich.

**STAFF NURSES — OPERATING ROOM NURSES:** For modern 650 bed tuberculosis hospital affiliated with Western Reserve University and approved by joint commission on accreditation of hospitals. 40 hr. 5 day wk. Salary $293-$323 with automatic increases. Full maintenance available at minimum rate. Housing for 2 or more nurses. Advancement for eligible applicants. Meets approved minimum employment standards of The State Nurses' Association. Apply Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

**STAFF & SURG:** (a) Staff; new hosp. recently completed; unit, univ. group; oppor. continuing studies; W. (b) Two staff; small gen'l hosp; coastal town, Alaska. (c) Staff & surg; one of leading hosps; NYC. (d) Surg. nurse; 10-man group; town 90,000 nr lge med. center, SW. (e) Surg; clinic & hosp; San Francisco area. RN10-8. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**SUPERVISORS:** (a) All depts; vol. gen'l hosp. currently under construction; completion next Spring; 300 beds increasing to 700; attrac. location, So. (b) OR; vol. gen'l hosp., 350 beds; service mainly surg; med. center, MW; $5000. (c) Ob; gen'l 250-bed hosp; univ. town, MW; $4500. (d) Thoracic surg; new dept: 400-bed hosp; affil. univ.; educ. oppor; E. (e) Ped. & psy; new 550-bed gen'l hosp; affil. med. school, SW. (f) Psy, ob, or, ped; general hosp, univ. city, outside US., altho tropical country, climate mild and pleasant. RN10-9. Burneice Larson, Medical Bureau, Palmolive Building, Chicago, Ill.

**X-RAY TECHNICIAN:** 44 hr. week, 2 weeks vacation with pay plus 7 paid holidays per year. Good salary with full maintenance. Private room in a beautiful nurses' home. We are 115 bed General Hospital located 35 miles from New York and are served by the DL&WRR and the Greyhound Bus Line. Apply Dover General Hospital, Jardine St., Dover, N. J.



**ADMINISTRATORS:** (a) RN qual anes, vol gen hosp. 40 beds, Wisc. (b) Asst., oppty to take full chge later, pref with exp as clin instr. 150 bed gen hosp. sm community, S. (c) Sm gen hosp resort twn MidE. (d) RN w/psych exp. small hosp, $5200 & full mtce, MW. (e) Vol gen hosp 30 beds, attrac sm twn, Iowa

**ANESTHETISTS:** (a) Apprv'd children's hosp, $400 & no call or $500 if call taken

*Woodward, continued*

alternate nites, island dependency of US. Tho considered tropical, climate mild. (b) Pref qual in admin, sm gen hosp. MW (c) Chief, average 70 majors and 100 minors per mo. Excel equip. Vol gen hosp 150 beds. $6000. Twn 20,000 S. (d) Grp 15 distinguished specialists. $7200 or fee-for-service. Min. call. Attrac college twn, MW. (e) Gen hosp. 100 beds, $5400 resort city, Fla. (f) 350 bed teach'g hosp, vol gen serv, E. (g) Male only, sm gen hosp, financial arrangements should net $7-9000, very desirable city, MW. Especially recommended.

**DIRECTOR OF NURSES:** (a) Nurs serv & ed. Lge teach'g hosp, impor. med sch. $7-9000, E. (b) Nurs Serv & Ed, well known lge vol gen hosp. $7-10,000. E. Recommended. (c) Vol gen hosp 75 beds, Southerner req. $6000. Univ. city, S. (d) Nurs. serv. only, 80 bed gen hosp. excel med staff, desirable resort city, SW. (e) Dir. of collegiate grad nurse prog. Rank of asst prof, coll twn 7000, S. (f) Nurs serv only, 200 bed TBc hosp. $6500 & full mtce. Lge city, MW. (g) Dir of 4 yr degree prog., impor med sch. $6000. North Central.

**FACULTY POSTS:** (a) Ed dir, sch of nurs has potential of 200 students & is temp NLNE accred, lge gen hosp, univ city, E. (b) Ed dir. 700 bed gen hosp, about $5800, Calif. (c) Nurs arts instr, faculty rank, collegiate sch of 70 students, to $5600, desirable twn, MidE. (d) Nurs arts instr, college affil sch, gen hosp 90 beds, to $4800, twn 90,000, MW. (e) Clin instr sch has enroll of 47. NLNE accred & coll affil. 150 bed gen hosp, to $4800, not far from Chicago. (f) Clin instr. class of 100 admitted each yr, temp NLNE accred, vol gen hosp 530 beds, to $5100, lge city, E.

**OFFICE, CLINIC, SCHOOL:** (a) Office & hotel, by 3 M.D.'s caring for guests & empl of luxury hotel, call alternated, gd sal start plus add'l compensation for call & Sunday work, impor univ med center, MidE. (b) Clinic, distinguished group of specialists, new bldg, univ city, W. (c) Resident for men's college div. of famous univ., supervision of 450 male students, state capital, S.

**PUBLIC HEALTH:** (a) PH Nurse, incl cons amt of clin work, to $5000, famous state capital, SW. (b) PH nursing consultant, supervise staff in several counties & consultation serv to related agencies, West mtn.

**STAFF & SURGICAL:** (a) Staff, 150 bed TBc hosp Alaska. (b) Surg. by well est clinic grp, city 30,000 SW. (c) Staff, small gen hosp well known resort city, West.

**SUPERVISORS:** (a) OR. 250 bed gen hosp, to $4800, well known city 35,000, W. (b) OR. 345 bed teach'g hosp, univ med center, MW. (c) Ped, lge gen hosp, to $5000, Calif. (d) Psych, 34 bed psych unit, 7 psychiatrists on staff, excel equip, 375 bed vol gen hosp, univ city, West Central.

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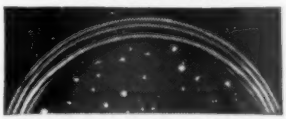

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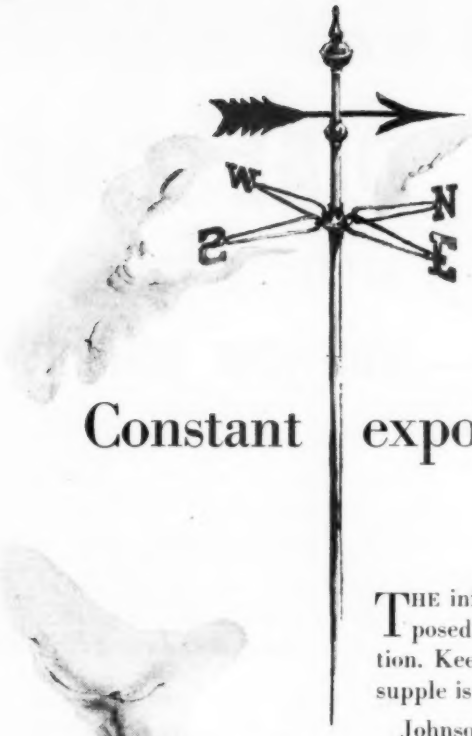


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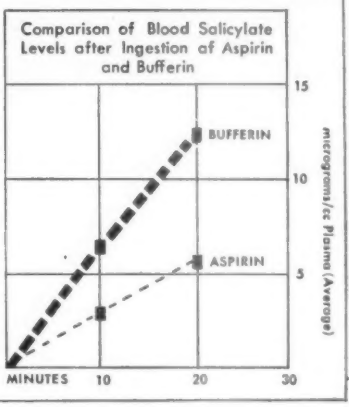


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In a series of 238 cases, 22 had a history of gastric distress due to aspirin but only one reported any distress after taking 2 Bufferin tablets (equivalent to 10 grains of aspirin).[1]

Bufferin's antacid ingredients protect the stomach against aspirin irritation. This has been clinically demonstrated on hundreds of patients.

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1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950

2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951


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